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ABSTRACT

This book provides an organized, systematic overview of the basic aspects of health program management, nursing practice, and human relations issues in camp nursing. A foremost assumption is that health care in most camps needs improvement. Good health is dependent upon interventions involving social, environmental, and lifestyle factors that impact health more than health care services alone. Professional registered nurses are the best prepared health care providers for most camps. Management skills, community health preparation, broad-based general education background, and emphasis on prevention and health promotion are integral parts of the baccalaureate degree in nursing. Each camp is a small community, and camp nurses must know the nature, characteristics, and informal politics of said community. Health care should be a collaborative effort among its members. A needs assessment survey by the Dean's Fund of the Intercollegiate Center for Nursing Education in Spokane, Washington was the basis for the information included in this book. Chapters cover traditional issues such as developing a health program, first aid, records, communicable diseases, and injury prevention; as well as more challenging community and professional issues of ethical behavior, violence, substance abuse, and sexuality. Appendices outline American Camping Association standards, staff and camper training in prevention and health promotion, procedures for analyzing accidents, OSHA regulations on occupational exposure to pathogens, and relevant developmental characteristics of young adults; provide sample checklists and recordkeeping forms; and list additional resources. Contains an index. (JAT)

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Kris Miller Lishner

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ED 385 402

Creating A Healthy Camp Community

a nurse's role

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Creating A Healthy Camp Community

a nurse's role

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Disclaimer. The purpose of this book is to help individuals who are formally trained in nursing practice to become more familiar with their profession in the camp setting. It should be recognized that nursing practice requires professional education and no individual who is untrained in nursing should use the information in this book as a substitute for professional training in nursing. Neither the publisher nor the authors of this book undertake to verify that individuals who use this book are trained appropriately. Nor do the publisher or authors assume any responsibility or liability for any consequences of the use of information in this book by unqualified staff. Further, the American Camping Association, Inc. and the authors hereby expressly disclaim any responsibility, liability or duty to administrators, camp personnel, and any program participants or their families, for any such liability arising out of injury, illness, or loss to any person by the failure of such administrators or camp personnel to provide appropriately trained health care staff or appropriate health care.

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I would like to extend my appreciation to all those who have helped shape my knowledge and understanding of camp nursing. From my days as a camper, to my summers as a camp nurse, to my experience as the parent of campers, many individuals have contributed to my evolving perception of camp's complex health care delivery system. This book provides an outline for camp nursing and camp health programs, as the entire country begins to focus on improving the health of children.

A special thank you goes to my family, who has contributed to my desire to offer the best health care possible. Thanks also to my co-author who exemplifies the professional dedication necessary for improvement of health services to all children and adolescents. – MAB

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Introduction

Purposes

The purpose of the book is to provide an organized, systematic overview of the basic aspects of health program management, nursing practice, and human relations issues in camp nursing. The book is also about changing the way health care is delivered in camps. The content included is based on recommendations of experienced camp nurses throughout North America and presents camp nursing as a complex, sophisticated, and demanding type of nursing practice. In the past, resources to assist the nurse in preparing for camp nursing have been limited. This book is one contribution to pull together new and existing information to fill this resource gap. Though primarily designed for professional nurses who practice nursing in camps, this book can serve as an important resource for camp directors, too.

Assumptions

Several assumptions underlie the material included here. First and foremost among these assumptions is that **health care in most camps needs improvement.** Health care in general has become complex, sophisticated, and increasingly difficult to understand over the past decades. Society has come to the realization that good health is dependent upon interventions involving the intricate social, environmental, and lifestyle factors that we know impact health far more than health care services alone. Life in general is much more complicated than even a decade ago. Expectations of parents, of children, of camps, and of nurses are higher.

Families expect competent and current health care for their members. Many camps must work to improve the quality of health care they provide beyond the "minimum" suggested by American Camping Association standards. Expectations of the American public are constantly increasing and have moved beyond what has traditionally been acceptable in camps.

Families want to believe staff of the camps their children attend are as concerned about the health of campers as they are about education and recreation. They are increasingly askir.g pointed, hard questions about the scope and quality of health services. Families want to know if training in the prevention of injuries receives as much time and attention as does training in how to do CPR on someone when injuries have not been prevented. Some parents want reassurance that the individual responsible for administering their child's medication at camp knows about the actions, side effects, and potential problems associated with the medication and can take appropriate action if a problem arises. Those camps that administer all medications without a second thought, or have only a first aider or EMT available in case of a crisis are not meeting the total health care needs of campers.

Nurses face the rising expectations of health care consumers in practice settings. The changes occurring in the health care system are not a surprise to most nurses, nor are the increasing demands of health care consumers. These changes do come as a surprise to some camp administrators who are unexpectedly confronted with them when an emergency, crisis, or lawsuit develops at their camp. We encourage camp directors to read this material thoughtfully. Some will be uncomfortable when they realize the extent to which they should revise or improve their health services. What might have been acceptable in the past no long can be accepted. Consumers and campers alike expect more from health services.

The second major assumption upon which this book is based is that **professional registered nurses are the best prepared health care providers for most camps**. Camps—both day and resident—need more than medical care, or the diagnosis and treatment of illness. Camps need health care, care that incorporates health promotion, prevention of illness and injury, early recognition of developing health problems, and management of acute and chronic health problems. This type of care requires more than physicians, more than nurses, more than pharmacists. It requires a whole team of professionals working together with health care consumers in a partnership designed to help the consumer become and stay as healthy as possible. "Nursing has redefined itself....It has staked out its territory and that territory is health..." (Shalala 1993). Nursing has also defined its role as the coordinator for the various services many disciplines now provide for clients independently.

The type of nurse best prepared for camp health care is still under debate. However, management skills, community health preparation, broad-based gen-

eral education background, and emphasis on prevention and health promotion needed for camp nursing practice are integral parts of only one type of basic nursing education program, the baccalaureate degree in nursing. New graduates from associate degree and diploma nursing programs do not have these skills as part of their basic education. Nurses with less basic academic preparation who have practiced in community health, school health, or similar settings, or who take additional course work may have obtained the skills needed for the challenges of camp nursing, but that must be assessed on an individual basis.

This book is not intended to be a training guide for individuals who are not professional registered nurses but are asked to fulfill these professional level responsibilities at camp. Nurses carry out their practice using high-level decision making, problem solving, communication, and assessment processes that cannot be learned in a day or two. These skills are more than "just common sense." Even so, this book can help camping professionals learn more about professional nursing and the contributions it can make to health in the camp community.

Some nurses may be surprised by some of the material in this book. It should deliver a loud wake up call for nurses who view camp as a pleasant way to spend a summer out of the pressure cooker environment of an acute care hospital or home health agency. Camp professionals need and have the right to expect well prepared professional nursing that meets diverse health needs of a wide variety of populations within a community setting. They need nurses who can function autonomously, be self-directed, and provide leadership in helping camps develop effective health programs that will endure from season to season. They need to experience high quality nursing care in order to recognize and appreciate it.

The third major assumption upon which this book is based is that **each camp is a small community**. Professional nurses work with the camp communities as a whole as well as with individual community members. Nurses must get to know the nature, characteristics, and informal politics of their camp community, as well as its strengths, problems, and health issues. Health care in camp communities should be a collaborative effort among the members of the community. The professional nurse should be a resource to the community in the roles of health program manager, educator, consultant, collaborator, and direct care provider. To be effective as the health team leader for the camp community, the nurse must be part of the community and participate in as much of camp life as possible.

Organization

The content included in the chapters that follow was selected as a result of a needs assessment of experienced camp nurses completed in spring 1992. In a study funded by the Dean's Fund of the Intercollegiate Center for Nursing Education in Spokane, Washington, Margaret Bruya and Kris Lishner mailed a

survey to nurses who were members of the Association of Camp Nurses (ACN) at that time. Those surveyed were asked to evaluate how important it was for nurses working at a camp for the first time to have various types of information. The respondents were asked to rate 44 potential content areas according to their importance for the novice camp nurse. These content areas were organized into general areas of health program management, clinical practice, and communication/ethical issues.

The response to the survey was tremendous. More than 70% of the members of ACN returned the questionnaires. While not all responses could be addressed, many included detailed comments and suggestions for content that has been included in the book. Ratings of content areas revealed that experienced camp nurses believed information on health program management was the area of highest need for new camp nurses. Highest ranked among management issues were record keeping, staff training, ACA standards, the health center, screening, and defining the nursing role at camp. Based on the needs assessment, management issues have received major emphasis in this publication. Chapters on community assessment, developing a health program and written health plan, and several others provide guidance for setting up camp health care systems that are based on community needs rather than hastily established policies when a new nurse arrives at camp.

Ranking of clinical practice issues in the needs assessment indicated that, in addition to managing emergencies and communicable diseases at camp, prevention and health education were considered extremely important by survey respondents. As a result, the theme of primary prevention and health promotion as critical parts of camp nursing practice are interwoven into almost every chapter in the book. This approach is consistent with evolving changes in the health care system, the need for cost effective health care in camps, and the emergence of nursing as the health profession that claims health as its territory.

Among communication and ethical issues, experienced camp nurses rated information about working with the camp director and camp counselors as most important for novice nurses. As a result, a chapter on working with others at camp has been included that emphasizes the camp director and other camp staff. Efforts have been made in other sections of the book to provide nurses with information on the health issues and responsibilities that camp directors and other staff face so that nurses can collaborate effectively with members of the camp community.

The need for resources to use in adapting to the unique situation in each camp community was evident in responses to the needs assessment. A chapter devoted entirely to resources has been included. It is not comprehensive, but does provide a starting point, especially for nurses with limited community health and health promotion/prevention experience.

Limitations

No publication on camp nursing, including this one, can be all things to all people. Nurses will need to use some of the suggestions in chapter fifteen, including networking, professional organizations, and library resources to prepare themselves for their camp roles and to build effective camp health programs.

For some camp directors this book may be their first introduction to the real and heretofore untapped potential of the camp nurse. Some may need more information than is provided here about the roles nurses are assuming in the evolving health care system. This is an ideal time for all camp professionals to increase collaboration and contact with nurses. Health care reform will have direct impact on camp health issues. Building a strong partnership between camping and nursing now can help ease the transitions and changes that lie ahead.

Day camp directors and directors of camps for individuals with special needs will note that no sections are designed specifically for their settings. This is because most information about comprehensive camp health services that applies to resident camps also applies to day camps and camps that specialize in special needs populations.

"When the only tool you have is a hammer, every situation that comes along begins to look like a nail" (Garbarino 1980). Nurses and camp directors have been hammering away at illness and injury in camps using a hammer solely comprised of first aid and emergency management skills. This book is designed to be an important addition to the tools nurses can use to provide the best possible nursing and health care in their camps. It also can be a tool for camp directors who want to collaborate with professional nurses to make their camps safer and healthier places for their campers.

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CHAPTER 1

The Camp Community

Kris Miller Lishner and Mark A. Lishner

The approach to professional camp nursing explained in this book is based on the idea that camps are small communities. In describing the camp as a "temporary community," Tom Slater (1984) argues that "community" is the most distinctive and indispensable attribute of camping (both day and residential camps), and supports his view with the following:

> Because of its essential nature, camping offers unique opportunities for building community. It involves many aspects of life — working, relaxing, eating, preparing food, washing up, making decisions, carrying out those decisions...it is a residential experience with all that means for shared living.
>
> — *Marshall and Merritt 1980, 21*

Like all communities, camps provide basic services for their members, including food, shelter, socialization, protection from harm, meaningful activity, and the other necessities of life. Each camp is unique, however, in how these basic services are provided and how individual needs are met. What makes camps appealing is the warm and friendly way people provide services to each other. Campers feel a sense of belonging and develop relationships with others during the camp experience.

Most successful camps have a strong internal culture that conveys the values, traditions, beliefs, rules, and standards that are the essence of each camp's unique identity. Because the camp community is only temporary, it requires a strong culture to preserve the camp's soul and spirit from year to year. The transfer of

the culture through staff and campers as the community comes together again each season is a phenomenon seldom seen in other aspects of our society.

Camping Past and Present

The concept of organized summer camp experiences for children originated in New England in the late 1800s. Private schools and religious groups established these first camps to provide children with an alternative to city life during the summer and to promote the spiritual development of the children who attended (Sargent 1927). The public accepted the value of camping experiences for children. As a result, tremendous growth occurred in camping in the first half of the 20th century. In 1935, several existing camping associations consolidated into what is now the American Camping Association, the professional organization for camps, camp directors, and camp staff.

Today, camp is available to millions of children and adults. Many camp services focus on client diversity and program specialization. Camps are available for all age groups and segments of the population and are offered in many countries throughout the world. There are camps that emphasize outdoor living skills, foreign-language immersion programs, or advanced skill development in music, arts, or sports. Some camps specialize in offering opportunities for children with chronic illnesses such as diabetes, cystic fibrosis, or cancer to meet and share experiences with children who have similar conditions. In other camps, children travel around the United States, or even in other countries, by bus, van, or bicycle. Also, many camps have extended their programs to serve families and older adult groups during some sessions.

Camp Characteristics That Influence Health Care

A healthy camp community is an important goal for nurses and for camps. Understanding the nature of the social institutions, internal culture, and traditions of a camp as a unique community is essential in developing health programs for the camp as a whole and for all the people who are part of that camp community. Camp means different things to each of us, based on our background and experiences. For the purposes of this book, the American Camping Association definition is the most useful:

> A sustained experience which provides a creative, recreational and educational opportunity in group living in the outdoors. It utilizes trained leadership and the resources of the natural surroundings to contribute to each camper's mental, physical, social, and spiritual growth.
>
> — *American Camping Association, 1993*

This definition of camping highlights individual development, the natural environment, and small group living, as integral parts of camp. Each of these aspects of camp effects the health needs and health care of campers and staff members.

Emphasis on Individual Development

Camps have a long history as social institutions dedicated to promoting physical, emotional, cognitive, and spiritual development among children and adults. Camps allow children and adults to experience nature, escape the stress and pressures of high-tech society, develop independence and self-reliance, form new friendships, and learn new skills. Personal accounts of summer camp as pivotal experiences or milestones in people's lives are common. Camp is a positive force for individual growth and development. This emphasis on personal growth and enrichment in camps is consistent with professional nursing approaches to holistic health care that address the bio-psycho-social-spiritual needs of individuals of all ages.

The Natural Environment

The outdoor setting is the distinguishing feature of camping for many people (Dimock 1969). It is surely the feature most familiar to people. From isolated wilderness environments in the north woods to well-maintained city parks, campers experience natural environments to varying degrees. However, for some campers these environments may be entirely new and unfamiliar. Nurses can play an important role in helping campers and staff adapt personal life styles and self-care habits to cope with the unique demands and physical risks of camp environments.

Small Group Living

The type and length of group living experiences vary markedly from camp to camp. Most people picture camps as small groups of children and adult counselors living together in cabins or tents in the woods for one to two weeks at a time. On the contrary, just as the natural environments of camps vary greatly, the types of group living experiences take many forms. This factor has significant impact on health care requirements in these settings.

Day Camps. Campers and staff are transported to a site in the morning and return home each evening. Lunch is eaten at camp, but food service may not be provided. These camps are usually located in urban or suburban sites; sometimes parks or public facilities are used. Coed groups of children ages eight to twelve most commonly attend. Some day camps cater specifically to preschool children, and some serve six to eight year olds or individuals with special needs. Sessions

vary in length, with five days being most common; some campers may attend several consecutive sessions. Typical sponsors are churches, youth services groups (Girl Scouts, Camp Fire, YMCA, etc.), state/municipal governments, and private individuals (for profit or not-for-profit). Seasonal staff often consists of college students and volunteers. Permanent staff generally are professional administrators. Day camps usually provide less specialization than resident camps, with more emphasis on general recreational activities (sports, arts and crafts, music, games).

The length of time campers and staff spend together at camp is one important determinant of how and when health needs are met. Because day campers return home at the end of each day, parents typically assume primary responsibility for daily decisions about the state of their child's health. The day camp traditionally has limited health supervision for the prevention of injury and illness on the campsite. Occasionally, camp health care providers continue medication or treat minor health problems or conditions that need follow up during camp.

Resident Camp. This is the traditional *sleep away* camp. Campers and staff live on site twenty-four hours a day for periods of a few days up to eight weeks or longer. These camps are usually located in rural or wilderness areas. They are self-contained with meals and health supervision provided. Typically, ten or less campers live together with one or more counselors in a tent, cabin, or other shelter. School-age children are the most common participants. Resident camps may have sessions or activities exclusively for boys only, girls only, coed groups, teenagers, older adults, or persons with special needs. Sponsors include churches, youth services groups (Girl Scouts, Camp Fire, YMCA, etc.), and private individuals (for profit and not-for-profit). Seasonal staff usually includes college students from the USA and other countries led by mature, professional administrators. Resident camps can offer specialization in activities such as outdoor living skills, sports, and intensive exposure to programs and services of the sponsoring agency.

Resident camps usually assume a greater degree of responsibility for the health care of everyone who lives on the campsite than day camps assume. Because staff and campers usually reside at these camps twenty-four hours per day, their regular health care providers may be some distance away. The parents of campers also may not be readily available, even by telephone. Health maintenance, as well as prevention and treatment of illness and injury, all become the responsibility of the resident camp staff.

Travel and Trip Camps. *Travel camps* use a van, bus, car, boat, or other motorized transportation to move from site to site (American Camping Association 1993). Length of sessions vary from three days to several weeks. Typical campers are older school-age children and teenagers. Travel camps specialize in programming that is based upon the environments the group

encounters as they move from location to location. These environments range from natural wilderness to urban environments and include travel in other countries.

Trip camps involve programming in which groups move from site to site under their own power (hiking) or by an "individually guided vehicle or animal" (bicycle, canoe, horse, etc.). Tripping may be the singular focus of a camp, or a specialized program within a camp offering other types of programming (American Camping Association 1993).

Both travel and trip camps can involve movement of groups over long distances. Some include travel in other countries. Staff leaders are mature adults who can assume high levels of responsibility in constantly changing environments.

Travel or tripping camps assume most of the responsibility for campers' daily health maintenance and management of health problems that arise. As in resident and day camps, travel/trip camp staff must assume primary responsibility for daily health supervision and obtaining needed health care for their campers. Campers may be away from home or a base camp for long periods of time, and as a result their regular health care providers usually are nonaccessible. Travel campers can be in multiple locations with limited or no health care facilities.

Special Needs Camps. Some day and resident camps primarily serve campers with special physical, cognitive, or emotional needs not easily accommodated in camp settings without specialized facilities and staff. Such camps provide opportunities for campers to socialize and to engage in small group and outdoor living experiences that are both therapeutic and enriching. Health care in camps specializing in serving children or adults with special health needs require health care professionals on site at all times when campers are present. Because health care is more complex and comprehensive in special needs camps, registered nurses are key staff. In addition, physicians, dietitians, physical therapists, special educators, psychologists, social workers, and other members of the health care team may spend time working with campers on site.

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CHAPTER 2

Health Care in the Camp Community

Kris Miller Lishner

Recipients of Health Care at Camp

As in any other small community, the types of nursing and health care services required in camps are dependent upon the needs of the community and its members. Geographic location, climate, organizational philosophy, types of programs or activities offered, and the background of the staff and campers are just a few of the many factors that combine to make each camp community distinctive. Camp nurses have the unusual opportunity to provide health care concurrently at several levels — to individuals, groups, and the camp community as a whole.

Individuals

Campers and camp staff make up the individual members of the camp community. Historically, both camping professionals and nurses focused on the health problems of individuals as opposed to groups within or the entire camp community. Responding to individual health problems represents *acute care* or restorative nursing in the camp community. Without systematic, organized prevention and health promotion efforts at the individual, group, and community levels, the camp nurse ends up providing only acute care. However, this traditional focus is shifting so that prevention and health promotion are assuming much greater emphasis in camps. Figure 2.1 provides examples of nursing interventions at the individual, group, and community levels.

Figure 2.1 **Examples of Health Intervention**

Level of Intervention	Type of Intervention
Individual	Treating a camper's athletes foot with medication
	Teaching the camper to dry feet carefully after swimming/showers
Group (camper unit and counselor)	Teaching counselor how to screen campers in unit for athlete's foot
	Helping campers and counselor in unit develop a plan to assure everyone wears thongs when their group takes showers
Community	Establishing a policy that thongs must be worn in showers
	Cleaning showers daily with commercially available disinfectant solutions to decrease fungal growth

Groups

Maintaining and promoting health among various groups within the camp community have received considerably less attention in the past than has acute, individually focused health care. Many different groups within a camp can have characteristics, backgrounds, experiences, or responsibilities that result in shared health needs or potential health problems. By focusing on common features among group members within the camp, the need for health promotion, wellness, and prevention efforts becomes more evident. For example, almost everyone who works in the kitchen at camp is at risk for burns from hot foods and equipment. Recognizing the risk to this group and planning prevention strategies for all of them as a unit can be effective in preventing burns. It is less effective to treat individual kitchen workers after they are burned and to send them back to the kitchen to be burned again. See figure 2.2 for examples of common groups within camp and their potential health problems.

Unit, tent, or cabin living groups are those that ordinarily require the most attention and effort by nurses. These groups take on many of the roles and responsibilities assumed by the family in campers' and staff members' home communities. The unit counselors are the adults who assume the responsibilities of parents or guardians in meeting basic camper needs twenty-four hours a day. Helping counselors find ways to meet camper health needs is a major part of the nursing role at camp.

Figure 2.2 **Examples of Common Health Needs of Groups within Camp**

Group	Potential Health Need/Problem
Trip staff	Hesitant to discuss health concerns with unfamiliar adults
	Higher risk of injury
	Management of camper medications on trips
	Safe food handling techniques
	Water contamination potential and purification techniques
	Appropriate backcountry bathroom procedures
First-time campers	Homesickness
	Fear of outdoor toilets
	Embarrassment over physical closeness with others
Counselors-in-training	Lack of experience in recognizing illness in children
	Transition to health role model for others
Youngest campers	Increased risk of injury, communicable illness, adjustment problems
	Need more help with personal hygiene and clothing selection
Staff with families at camp	Camp long distance from regular health care providers for their young children
	Increased stress when family members are ill
Campers with physical disabilities	Changes in medication routines required while at camp
	Difficulty adapting to weather changes (humidity, temperature)
International staff	Limited knowledge of American health care system
Teenage campers	Hesitant to discuss health concerns with unfamiliar adults
	Higher risk of injury

Total Community

Everyone and every aspect of camp life are affected by health care that addresses issues at the camp community level. Food handling, environmental sanitation, injury control, management of communicable diseases, and program intensity (general stress and fatigue levels) are some of the health issues affecting the entire camp. Despite their importance, identification and management of health issues at the total camp community level are seldom systematic or visible processes in most camps.

Maintaining and promoting health at the camp community level is the shared responsibility of community members and the sponsoring agency. Health problems are managed at the community level by using such strategies as policy development and implementation, program decision-making, and staff training.

The camp director and other administrative staff have considerable authority in making decisions in almost every aspect of camp life that affect total camp health. Camp nurses, who often are the only health care professionals directly involved in day-to-day life at camp, can lead the collaborative effort in developing a healthy camp community because of their education and background in health care.

Types of Health Care at Camp

Nurses who work in camps confront a wide variety of needs in the individuals, groups, and communities with whom they work. While many different types of health care are required to meet this multitude of needs, this book emphasizes acute care, preventive care, and health promotion as being most appropriate for camp settings.

The terms used in this book have been used in health care literature for many years, but they may be unfamiliar to camping professionals. Because the media confuses the public with trendy health and fitness jargon, including dieting fads and self-help approaches, time spent clarifying terms and the concepts they represent is a wise investment for both the nurse and the camp director. It's essential for both nurses and camp staff to use key words in the same way to build good health care programs.

Acute Care and Emergency Treatment

The most basic level of health care camps must provide campers and staff is acute care for illness and injury. Some camps accomplish this by providing first aid until campers or staff can be referred to a physician or emergency room or sent home to their parents. Camps may use emergency medical technicians (EMTs) or staff certified in first aid to manage these situations. Other camps use the professional judgment and expertise of a registered nurse to assess health

status and appropriately manage or refer acute problems based on seriousness. Common, minor health problems such as colds, sore throats, insect bites, cuts, and minor burns can be managed safely and economically at camp by the nurse. Management of acute complications of minor illnesses or moderate to severe illness/injury is not appropriate in the camp setting unless the camp has an on-site physician and suitable equipment. Major problems should be referred to a physician and/or urgent care facility.

Preventive Care

Prevention of illness and injury should be a major goal of the camp health program. More than any other health care providers, nurses are uniquely qualified to turn the camp community's attention to preventive health care. The three levels of prevention are outlined in figure 2.3.

Figure 2.3 **Levels of Prevention**

Primary Prevention

Preventing a health problem before it occurs (Leavell and Clark 1958). Usually applied to healthy individuals with the goal of decreasing the likelihood of specific illness or injuries and improving the ability of individuals to resist harmful force s (Murray and Zentner 1993; Edelman and Mandle 1990). Primary prevention includes both specific protection and health promotion.

Specific protection	*Health promotion*
Instituting measures to prevent particular illness or injury (Leavell and Clark 1958)	**Measures to maintain or improve the general health of individuals (Swanson and Albrecht 1993); may include optimizing the environment and supporting healthy living (Stanhope and Lancaster 1992)**
Increasing fluid intake of campers and staff during hot weather (dehydration)	Reducing environmental hazards in cabin/tent areas
Requiring current immunizations (communicable diseases)	General health education
Testing swimming ability of campers and staff at beginning of camp (drowning)	Providing nutritionally balanced meals in dining room and on trips
Suggesting use of sunscreen by campers and staff (sunburn)	Monitoring and managing activity and stress levels

continued

Table 2.3 **Levels of Prevention (continued)**

Secondary Prevention	
Early detection and prompt treatment at earliest stage (Leavell and Clark 1958) or limiting disability by arresting progression of illness. Screening is the most common type of secondary prevention.	
Performing tick checks after hikes	Daily visual inspection of campers by counselors
Screening campers for communicable illnesses upon arrival at camp	Sending staff member with red eardrum to the camp physician for treatment
Tertiary Prevention	
Minimizing the effects of disease or disability. Focus on preventing complications or deterioration (Swanson and Albrecht 1993). Includes rehabilitation.	
Minimizing complications	
Socializing individuals with disabilities into regular camp programming	Helping a diabetic camper select appropriate foods in the dining room
Swimming restrictions for camper with external otitis	Assisting with skin care for a camper with paraplegia

Primary Prevention. Health promotion and specific protection efforts are both key to primary prevention. Specific protection efforts should be aimed at potentially serious and commonly occurring health problems. Communicable illnesses (colds, coughs, gastroenteritis, etc.) and minor injuries are the most frequently occurring health problems in most camps (Lishner 1986; Lishner 1988; Otto 1980; Rotman and Schmalz 1977; Schwartz 1980). The most serious, life threatening problems historically have been vehicular injuries and drownings, but many other health problems could be disabling or fatal (Lisella and Johnson 1980). Specific protection can be built into camp health programs by systematically identifying potential health problems and designing strategies to prevent them.

Camp staff may neglect to consider some highly effective forms of specific protection as health care or health-related. American Camping Association standards regarding waterfront management, transportation, and food handling are good examples. Most of these standards are primary prevention measures designed to reduce injury and illness at the camp community level. Other examples of specific protection include removing poison ivy/oak vegetation from

areas of heavy use in camp (community-intervention strategy), having a camper wear sunscreen when outdoors (individual-intervention strategy), and providing in-camp alternatives to alcohol-centered out-of-camp activities during counselors' time off (group-intervention strategy).

Health promotion helps campers and staff develop healthy lifestyles and can become an important part of camp programming. Changes in attitudes about health care place increasing pressure on camps to make health promotion a higher priority in programs. The real challenge in health promotion involves reaching consensus on which health measures or practices to encourage and how this can be accomplished. Camp sponsoring agencies, administrators, and staff have diverse beliefs about what constitutes a healthy lifestyle. They may all differ greatly in what they are willing to do to promote health. For example, each of the following health promotion strategies could meet with varying levels of acceptance and rejection:

- Including a one-hour rest period in the camp schedule each afternoon
- Teaching stress management techniques to all staff during staff training
- Removing all salt and sugar containers from tables in the dining room
- Reducing fried foods and prepackaged foods in the menu

Promoting health is less concrete and visible in the camp community than is treating obvious health problems. To be successful, health promotion must be a community-wide effort. Nurses can be leaders, collaborators, and consultants in health promotion; but, to be effective, it must be a community investment, not the responsibility of one individual or group.

Secondary Prevention. Part of traditional acute care is detecting and treating an illness or injury early so that it does not become more serious. Camp nurses provide secondary prevention when they carry out formal and informal health assessments on campers and staff, perform a strep screen, refer individuals with health problems to the camp physician, or provide direct treatment of minor health problems such as blisters. As with other aspects of health care and camp programming, secondary prevention may vary with specific camp practices and populations served.

Tertiary Prevention. Promoting rehabilitation and providing access for the disabled historically have been the focus of camps that serve individuals with special needs. All camps now are serving more individuals with disabilities and other special needs. As a result, most camps would benefit from strengthening tertiary prevention in their health programs. Camp nurses assume a great deal of responsibility in tertiary prevention. They administer medications to and provide treatments for individuals with disabilities, help them adapt to the camp environment, and assist staff in meeting the daily needs of all campers.

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CHAPTER 3

The Nurse in the Camp Community

Kris Miller Lishner and Margaret Auld Bruya

Camp nursing is a composite of nursing practices from a variety of settings: schools, emergency rooms, community health, pediatrics, outpatient clinics, university student health centers, and others. Whereas several people in camp may be trained in first aid, the nurse often is the only on-site professional health staff for the entire camp. He or she will be called upon to provide services ranging from emergency treatment to preventive care, and from health counseling to technical advice.

Nursing Roles in the Camp Community

Camp nurses assume many roles in carrying out their diverse responsibilities. Among these are direct care provider, program manager, educator, health counselor, and consultant.

Direct Care Provider

As a direct care provider, the camp nurse often has to assess and intervene to resolve health problems that arise at the campsite. Many daily routines and tasks focus on monitoring the health status of individuals or groups. Examples of typical direct-care-provider activities a camp nurse carries out during a twenty-four-hour period include:

- Health screening of a group of campers going on a canoe trip
- Nursing care of campers/staff on bed rest in the health center
- Completing a physical assessment and taking a camper with shortness of breath to a local ER
- Holding health center hours during which she or he cleans and rebandages a blister, administers medications campers and staff brought to camp from home, performs strep screens on campers with sore throats
- Helping a diabetic camper monitor blood sugar
- Performing an assessment on a staff member with menstrual cramps and administering acetaminophen under standing orders from the camp physician

Health Program Manager

First-time camp nurses often are surprised at the amount of time and energy they spend managing the health center and health program. As a manager, the nurse works with camp administrators and staff to develop and implement the camp health program. The camp nurse must formulate and implement health policies and procedures, keep health records, obtain supplies and equipment for the health center, monitor injury and illness patterns in the units, implement the bloodborne pathogens plan, and evaluate the health care program. These are just some of the management responsibilities a camp nurse may have.

Health Educator

The camp nurse is also a teacher. Both formally and informally, he or she continually trains staff and campers. Instructing staff in how to make health observations of their campers, how to take care of their own health, how to prevent common illnesses and injuries among their campers, and how to deal with specific health conditions a camper may have are important aspects of the nurses role as educator. In addition the camp nurse is constantly teaching the campers. Helping campers understand how to stay healthy in the camp environment, avoid injuries, and manage medications and treatments prescribed are just a few examples of how the camp nurse educates the campers.

Health Counselor/Collaborator

In this role, the camp nurse collaborates with camp community members as they make decisions about beliefs and behavior that influence physical and mental health. As an educator, the nurse provides information. As a counselor/collabo-

rator, the nurse offers alternatives, strategies, support, encouragement, and active listening. On the group level, health counseling activities at camp might include working with a counselor to develop ways to improve campers' food choices in the dining room or working with a unit director to motivate counselors to be good health role models for their campers. On an individual level, the camp nurse might work together with the camper who has diabetes to find the least obtrusive ways of working blood glucose monitoring and insulin injections into the camp daily routine. Also on the individual level, the nurse might provide mental health counseling to a day camper who is having trouble adjusting to camp. The nurse might also collaborate with the camper's counselor to help the camper make at least one new friend in his unit.

Consultant

The camp nurse's expertise as a health professional is a real asset to camp administrators, staff, campers, and parents. Providing expert advice, identifying resources, and evaluating the health program are all aspects of the nurse's role as consultant. The nurse's knowledge of health care systems can be useful to the camp director who is exploring alternatives to local community emergency services or the current camp physician. The camp nurse is sometimes the initial expert consultant for the camp director when there is a case of suspected child, spouse, or elder abuse. If a unit director wants to develop a stress management program for unit counselors, the camp nurse can obtain or direct others to the relevant materials and literature on which to base the program, as well as provide assistance in designing the program. Also as more camps develop plans to include more campers with special needs or disabilities, the camp nurse's role as consultant becomes crucial. Finally, experienced camp nurses also can serve as consultants for first-time camp nurses.

Some nurses' devote their entire practice in camp health to consulting. For example, some day camps may choose not to have a nurse on site, but instead use an EMT or first aider to provide emergency response care. In this situation, a professional nurse could be used as a consultant to check all medications to make sure they are safe, appropriate, and accompanied by adequate instructions. That nurse also might provide advice on injury and communicable disease control for the individual day camp community.

In addition to her roles as direct care provider, health program manager, educator, counselor/collaborator, and consultant, the camp nurse serves as a health advocate, researcher, and camp community member. The nurse is an advocate for improved health both inside and outside of camp. Camp nurses see the needs of groups served in camps from unique and different perspectives. In working with children, older adults, or individuals with chronic health problems, the nurse is the person best qualified to recognize and advocate for their health

care needs at camp. After the camp season, they can use their expertise to work with camping professionals and camping organizations, other health care providers, and service organizations to improve health services in camps, and to improve coordination of camp and community health services.

As the complexity and scope of camp health care increase, camp nurses will need to become more involved in research. Very few studies on health care, nursing care, or illness and injuries in camp exist. Camp nurses contribute to the scientific basis for camp nursing by observing trends and identifying problems to investigate in their practice. The camp nurse also uses relevant research findings available in other health care settings to solve problems or develop interventions for camp health problems.

Above all, it is essential for camp nurses to become members of the camp community. Despite their unique responsibilities, camp nurses can and should participate in all aspects of camp life. Eating with campers and staff, taking part in camp events, and joining in recreational activities and camp program whenever possible increases the nurse's sense of belonging to the community. Also, the more involved nurses are in daily camp life, the more information they have to promote health. Most important, participation in community activities allows other camp members to know and accept the nurse as an integral part of the camp community. For the nurse who lives on site, the camp may replace home, family, and customary community for a period of time.

The time and emphasis nurses give to each of these roles in any given camp will be determined by the philosophy and goals of the camp, as well as the scope of the health program. What also determines how much time each nurse gives to these various capacities is her background and personal characteristics.

Qualifications and Skills Needed for Camp Nursing

The nurse at camp functions much more independently and autonomously than nurses in hospitals, clinics, or home health settings. Physical facilities, supplies, and support services can be extremely limited in the camp setting. Camp nurses need education and experience that prepares them to work without the institutional structure of hospitals and to manage the high and complex levels of responsibility inherent in camp settings. They need personal characteristics that allow them to adapt quickly to the spontaneity and camaraderie of camp life. The camp nurse must also be prepared to practice within the legal boundaries of nursing of the state in which the camp is located.

Education

Basic professional education for the camp nurse should consist of completion of a diploma, associate of arts (AA), or baccalaureate nursing (BS) program that prepares the individual to take the licensure exam to practice as a registered nurse. The nurse's professional education should have included or be supplemented by course work in community health nursing. For large camps and/or those that serve campers with very specialized health needs, more advanced nursing education might be required. A master's degree in nursing or advanced registered nurse practitioner (ARNP) preparation is very helpful when additional leadership, management, and primary care skills are required. Full time positions in conference center or year-round camping are examples of situations in which advanced nursing practice skills may be needed.

Knowledge of human development, especially child, adolescent, and young adult development, is very important. Understanding camper and staff behavior and what motivates them are basic to developing successful camp health programs. The camp nurse needs the ability to recognize the wide range of individual behaviors that are normal in new situations and the effects of stress on normal behavior.

Professional Experience

The types of campers served and the scope of the camp health program determine how much prior professional experiences will benefit the camp nurse. For most camps serving children, nursing experience in pediatric, outpatient, community or public health, university health services, or school nursing is helpful. If the camp serves older adults or adults with disabilities, additional experience in a nursing home or other community settings working with these groups is beneficial. Previous nursing practice that has included prevention and health promotion should be highly valued in the camp setting. Experience with healthy children and common illnesses of childhood are especially helpful.

Camp directors often recruit nurses with emergency room or critical care skills. Responding to life threatening situations occasionally may be necessary at camp. However, on-site care should include only first response to emergencies and major health problems followed immediately by transfer to acute care facilities for full treatment. The emergency care at camp can be provided by EMTs, paramedics, and first aiders, as well as nurses. Using previous eduction and experiences to prevent major illness and emergencies should be the highest priority for camp nurses.

Personal Characteristics

Those who have previously described the personal qualities that are needed in the camp nurse have included humor, independence, good physical and emotional health, maturity, integrity, concern for children, openness, warmth, happy personality, and approachability (Casey 1981; Auld and Ehlke 1985; Hamessley 1987). These traits are desirable in all camp staff. For camp nurses, however, no personal characteristics are more important than are creativity, adaptability, and good interpersonal skills. Being an independent decision maker also is essential in most camps.

Camp nurses often must find alternatives to standard health care equipment, supplies, techniques, and procedures. Limited facilities and financial constraints on health care in camps prohibit use of many materials nurses use in highly technical environments. There are no realistic means of paying for (nor need for) crash carts, large quantities of sterile supplies, and sophisticated diagnostic equipment. There also are no dietary, housekeeping, or pharmacy departments. Camp nurses themselves may go to the kitchen to get trays for health center patients, drive to the pharmacy for prescriptions, and clean the health center (including the toilets).

Along with the ability to adapt to different situations, the camp nurse should have strong interpersonal skills. Camp nursing is very much a people-oriented job. It requires relating to people of all ages and backgrounds. Open, honest, but *tactful* communication is required with staff, campers, and parents. The nurse works closely with young adult staff who are highly responsible for their campers, but who may not have enough knowledge and experience with which to meet these responsibilities. The nurse must be assertive, without being aggressive, to make sure health care issues get top priority among the diverse issues camp directors manage daily.

Many nurses practice alone at camp. They may be the only nurse or the only health care professional in camp or in a large geographical area. There may be no more-experienced supervisor or expert available with whom to consult in new or unfamiliar situations. Other nurses who could offer professional support or feedback may not be accessible. Successful camp nurses must be comfortable and secure in making their own decisions and using their problem solving skills without the resources and structure that hospitals and other traditional health care settings provide.

The Nurse in the Organizational System at Camp

Employment Arrangements

In most situations, the nurse will be interviewed and hired by the camp director, who will be the nurse's immediate supervisor during the camp season. Figure 3.1 summarizes some important issues that should be discussed before the nurse accepts a camp position.

Figure 3.1 **Questions to Ask About the Camp Nurse Position**

- Is the camp accredited by the American Camping Association?
- How much time would the nurse spend on prevention and health promotion at camp?
- Is there a written job description?
- Are there standing orders and clearly outlined goals, policies, and procedures for the health program and health care plan? Are they reviewed annually? Is the nurse involved in the review and revision process?
- Is the nurse considered part of the camp's administrative staff?
- What are the arrangements for coverage on the nurse's time off?
- How much time off per week will the nurse have?
- What percentage of the campers and staff have special physical or mental needs?
- Is there more than one health staff member if the number of campers exceeds 150?
- When there are two or more health staff, are their clearly defined lines of accountability and responsibility for administrative decision-making among the health staff?
- What non-nursing responsibilities will the nurse have?
- Will the nurse have backup help when it becomes necessary? What or who is the backup help?
- Who is responsible for transporting campers and staff to the camp physician?
- Who is responsible for picking up prescriptions and other health supplies?
- What level of privacy is provided by the living arrangements for the nurse?
- How does the salary compare with those paid in other camps in the area?
- What benefits does the camp offer besides salary?
- Who orders health care supplies and sets up, inventories, and closes the health care center?

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The nurse needs basic information about the camp. The number of campers, length of sessions, program emphases (sports, outdoor living skills, music, canoe trips, etc.), and background of the staff and campers are important. The nurse also should ask about accreditation of the camp by the American Camping Association. Accreditation indicates the camp subscribes to at least minimum standards set by camping professionals concerning administration, program, facilities, personnel, and health care.

Equally important to the nurse is information about the nature of the camp health program and the nurse position. The comprehensiveness and sophistication of the health program in place should be assessed. The camp might need substantial health program development. For the nurse with leadership and management skills this can be an exciting challenge. Reviewing the camp's written health care plan, written policies and procedures, and nurse job description can provide an overview of the status of the health program and the role of the nurse.

The camp director and prospective nurse should thoroughly discuss workload, time off, and coverage during the nurse's absence from the campsite. There are no definitive guidelines about minimum or ideal nurse to camper ratios. Hamessley (1987) recommends a ratio of one nurse to 150 healthy campers, with full-time help if the camp enrolls over 200 campers. But, the type of program, climate, living conditions, and emphasis of the health program all greatly affect the workload of the nurse.

Camp health programs with an acute care emphasis could have more ill and injured campers than those with strong prevention and health promotion efforts. Nurses in resident camps have twenty-four-hour-a-day responsibility. If campers are frequently admitted to the health center for inpatient care, the workload of the nurse increases. On the other hand, developing prevention and health promotion programs can be time consuming and involve the nurse in extensive one-to-one teaching and collaboration activities. Ways to make best use of the nurse's time should be explored. Some tasks can be delegated by the nurse to other staff members. Another staff member can transport campers to the physician or emergency services, pick up prescriptions, get trays for inpatients, assist with screening and similar functions.

Camp nurses with twenty-four-hour-a-day responsibility usually have less time off than do nurses in more traditional health care settings. American Camping Association standards set minimum time off guidelines for all camp staff that also apply to the nurse. Some nurses hesitate to take time off or leave camp without replacement coverage by an appropriately prepared professional. The nurse and the camp director both should have a clear understanding of time off and coverage for the nurse before the nurse accepts a camp position.

Given the around-the-clock responsibilities with little time off, the nurse new to the setting might expect a salary commensurate to these heavy duties.

However, the weekly camp salary can be as little as one third or less the amount paid per week for an acute care nurse. Nurses need to prove their value in camp settings as well as receive respect and recognition for their professional knowledge. When camp nurses limit their role to providing first aid and administering medications campers bring from home, camp directors have difficulty justifying a salary higher than that of a typical staff member trained as a first aider.

Even in camps where nursing skills are highly valued and optimally used, financial constraints can limit salaries. Many camps, especially those sponsored by youth agencies, have small budgets. Paying nursing salaries that are competitive with those of nurses working in local acute care agencies and hospitals would consume much of the budget for staff. Prospective camp nurses should insist on a salary that is comparable to other camps in the region. Higher salaries should be expected in camps specializing in children or adults with exceptional needs and camps located long distances from health care facilities.

Nurses can explore benefits the camp provides in addition to salary. Resident camps always provide meals and often include laundry service, liability insurance, and reimbursement for the cost of licensure in the state. Also camp nurses can negotiate a waiver of camp fees for their child or children. This is a valuable benefit because free enrollment for a child can be worth several thousand dollars. In fact, some nurses seek camp employment as a means of providing their child with a camp experience they could not otherwise afford. The nurse also can investigate arrangements for a spouse to live at the camp during the camp season, so the couple or entire family can enjoy the advantages of camp life.

Member of the Administrative Team

The camp nurse should be a part of the camp administrative or management team, just as the health program should be an integral part of the camp community. Because health care has become so specialized and the skills used by the nurse may be unfamiliar to camp administrators, both the camp nurse and the health program are at risk of becoming detached or isolated from the mainstream of camp life and administrative decision making. As a result, the health program may then become excessively problem- or illness-oriented and not meet the true needs of the camp community. If a nurse is interested in prevention and health promotion, he or she should examine the camp's organizational chart and discuss the role of the nurse on the camp management team before accepting employment.

Accountability of the Camp Nurse

Questions frequently arise about responsibility for clinical practice and legal accountability of camp nurses. This is because camp health care is less rigidly

structured and regulated than that in traditional health care settings such as hospitals, clinics, and even home health care. The nurse usually works more independently at camp than in most other health care settings. Authoritative sources concerning nursing practice in camps are limited. Unlike in more traditional settings, health care at camp has not been highly regulated by state agencies. Most camp employment is short term and does not receive much attention by state boards of nursing or professional nursing organizations. However, basic nursing standards, codes of ethics, and the state mechanisms for regulating professional practice can provide some guidance for nurses and camp directors.

Some of the most common practice and accountability issues that arise for camp nurses are listed in figure 3.2. Both administrators and camp nurses will need expert legal advice with many of these issues. Requirements and limits vary greatly by state. See figure 3.2 for authoritative sources of information about practice and legal issues concerning nursing and camp health care. It must be emphasized that it is not within the scope of this publication to provide legal guidance for camp administrators or nurses. The sources listed here will provide useful information, but the relevant issues in the figure must be addressed individually by camps and nurses through appropriate routes.

Accountability to the Camp Director

Camp directors supervise and evaluate nurses as members of the camp administrative team and as staff members. As manager of the health center and health program, the nurse is directly accountable to the camp director. The director evaluates the nurses skill in working with camp staff, in carrying out effective staff training, and in collaborating and consulting with staff on health issues. Although usually the nurse's immediate supervisor, the camp director seldom has the professional qualifications to evaluate the nurse's clinical decision-making abilities and direct patient care skills. For example, the director could reasonably set criteria for keeping the health center clean and accessible to campers and staff and evaluate the nurse's ability to perform that function. However, she would not be in a position to judge whether or not the nurse used an appropriate dressing on a wound or to tell the nurse when to discontinue a medication prescribed by the camp physician. Because camp nurses work autonomously and must be self-directed, they must be more independent in evaluating their own decision-making skills and clinical judgments than nurses in traditional, structured settings.

Figure 3.2 **Issues and Sources**

Legal/Accountability Issues in Camp Health Care

Each of the following are issues that are often raised about camp health care. Each should be addressed individually by camps and nurses.

General Issues

- Need for RN licensure in state where camp located
- Ability of foreign nurses to practice in camps
- Protection of the title *nurse*
- Advanced nursing practice (ARNP, FNP, PNP) and prescriptive authority
- Limits on practice by licensed/unlicensed staff
- Delegation of nursing tasks to unlicensed personnel
- Obligation/mechanisms for reporting child abuse, elder abuse, spouse abuse, date rape, sexually transmitted disease

Management of Medications Issues

- Use of physician's standing orders for medications
- Administration of over-the-counter medications
- Administration of medications with no physician's order
- Administration of medications prescribed by out-of-state physician or physician with no U.S. license
- Administration of unlabeled or inappropriately labeled medications
- Administration of medications not approved for use in the U.S.

Authoritative Sources of Information on Legal/Accountability Issues

- State nurse practice act
- State board of nurse registration/licensure
- State attorney general's office
- Camp legal counsel

Accountability to Patients and the Public

Despite the autonomy inherent in camp nursing, all nurses are professionally and legally accountable to their employer and their patients for their nursing care (American Nurses Association 1987). The American Nurses Association *Code for Nurses* (1985) provides broad guidelines for ethical nursing practice. The nurse practice act in the state in which the camp is located provides the legal basis for nursing practice. The state board of nurse licensure or registration regulates the practice of nursing on behalf of the state and the public. Camp nurses should be familiar with the state practice act in the camp's state, professional nursing standards, and *Code of Ethics* (American Nurses Association 1991, 1985).

Licensure. For individuals to practice nursing and to call themselves registered nurses, a current, *unencumbered* license is required in each state where the nurse actually practices. If a nurse goes to another state to be a camp nurse for the summer, a license to practice in that state must be obtained *before* camp begins. The process of obtaining a license in another state (interstate endorsement) is usually not difficult, but it can take up to two months. During the job seeking and hiring process, nurses and camp directors should plan ahead to allow adequate time for the nurse to apply for and receive a license before the beginning of camp. Practice without a valid license is grounds for action against the person by the state regulatory agency.

State licensure laws also apply to nurses from other countries. Licensure in another country does *not* cover practice within the United States, so foreign nurses must obtain an American license in the state in which they will practice. If they do not obtain an American license, nurses licensed in other countries cannot legally practice nursing in the United States, nor can they be called a "nurse" or a "camp nurse." This licensing process can take an especially long time, i.e., six to eight months, and might require testing or supplemental courses. Often the time constraints on the licensure process prohibit foreign nurses from practicing as registered nurses in camps. Sometimes they can be employed as assistants to registered nurses or first-aiders, but they cannot call themselves registered nurses, nor engage in activities defined as nursing by the nurse practice act in the state where the camp is located. Consultation with the state nurse licensure board and familiarity with the state nursing practice act and licensure regulations in their state are essential for camp directors and registered nurses who work with nurses from other countries.

At the time of hiring, the employer should ask to see the nurse's license, and the nurse must show the employer his or her wallet-sized license as verification of current licensure. Some states now advise that copies of licenses *not* be made because of problems with license forgery. Nurses and camp directors should be aware of the state board's recommendations before the camp makes a copy of the license to keep on file.

State Nursing Practice Acts. The nurse practice act in each state delineates the scope of nursing practice in that state. Because each state's law is different, both the camp director and the nurse need to be familiar with the extent and limits of the current nurse practice act in the state where the camp is located. If not already available through the camp, a copy of the practice act can be obtained by writing or phoning the state board of nursing.

Nurse practice acts and state boards of nursing also regulate the practice of nurses who hold advanced education and/or certification. These nurses are prepared in a formal educational program to assume an expanded role in providing health care services. Nurses who have this advanced education and take a certifying examination may be separately licensed in some states as advanced registered nurse practitioners (ARNP). They are often known professionally as nurse practitioners (e.g., family nurse practitioner or pediatric nurse practitioner). Nurse practitioners may legally assume functions beyond the normal scope of professional nursing if appropriately licensed and approved by the state board. Examples of these expanded skills include advanced physical assessment and, in some states, prescriptive authority for designated drugs.

Status of Other Staff. Confusion often exists about the status of licensed and unlicensed personnel providing health services at camp. Individuals licensed as physicians, registered nurses, and practical nurses are just that — licensed by an individual state to perform specific professional services defined by law. The scope of practice for each of these professionals is different, and the licenses they hold determine the legal limits of their practices.

In many states, the law also *protects* the practice of those holding the license and prohibits unlicensed, unqualified individuals from carrying out the activities covered by the license. For example, in most states, physicians are not licensed to carry out nursing care, nurses are not licensed to carry out medical care, and EMTs and first-aiders are not licensed to independently perform any of the professional activities assigned exclusively to physicians or nurses. The titles "nurse" and "physician" also may be protected by state practice acts. That is, a camp cannot refer to the first-aider or EMT in camp as the "Camp Nurse" or "Camp Doctor". The implications of individual state laws regarding each issue with each type of license must be interpreted by the state licensing board and/or state attorney general's office.

Delegation to Unlicensed Staff. Registered nurses can delegate tasks to unlicensed staff; however, the registered nurse who delegates must first assess whether or not the nursing act can properly and safely be performed by the person to whom it is delegated without jeopardizing patient welfare. Delegating a dressing change or administration of a camper's medication to a trip counselor for an overnight campout requires that the nurse instruct the unlicensed person carefully about how to carry out these procedures. Verification of the staff

member's competency also is important. The nurse retains responsibility and accountability for the nursing care of the camper, including assessment, evaluation, and documentation. Delegation of responsibilities to unlicensed personnel is currently undergoing considerable review by state boards of nursing. Camps and camp nurses should check with their individual state boards or state nursing organizations for the most current guidelines available.

Protection Against Legal Claims

The best protection against lawsuits is skilled nursing practice based on professional standards and carried out within the guidelines established by the state board of nursing. Detailed written documentation also is a preventive measure in camps, just as it is in other health care settings. Unfortunately, even the most careful and skilled nurse can become involved in situations that may end up in court.

Camp nurses should carry their own individual malpractice insurance. Like hospitals and other health care institutions, camps usually carry some type of general liability or malpractice insurance on staff. The purpose of this insurance is to protect the camp against claims. If the best interest of the nurse involved in a suit is different from that of the camp, the camp's attorney and/or insurance company may ignore what is best for the nurse in settling the claim.

Nurses with their own liability insurance have an attorney and an insurance company to protect their interests. Nursing and legal experts recommend individual malpractice insurance for nurses in all practice settings. These same recommendations are equally valid for camp settings.

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CHAPTER 4

Developing the Health Program

Kris Miller Lishner

Prevention, health promotion, and health restoration in camp are continuous processes that are the responsibility of all members of the camp community. The camp nurse is the health professional most often directly responsible for organizing and translating these processes into a systematic health program. While the nurse and other health staff often change from summer to summer, once developed, the health program should be a permanent part of the camp community, changing only as health needs of the community members change. Creating a written health care plan that outlines goals and components is necessary to provide consistency and stability in the camp health through consecutive seasons. This chapter describes ways to gather the information necessary to create a comprehensive camp health program.

Two important aspects of developing a health program must be emphasized first: The time the development process takes and the importance of involving camp community members in the process. As temporary small communities, most camps do not have the resources to develop strong, comprehensive health programs. Quality programs cannot be created in a few days or a few weeks; nor is it simply a matter of hiring a qualified health professional. Nurses and camp directors should view the process as one that can take several summers to complete.

The participation of key administrative, program and counseling staff, and board members is essential. Even volunteers, parents, and campers can be involved. Everyone associated with the camp has a role in the health program. If they are involved in development, they will acquire a sense of ownership and commitment to the health program.

Sources of Information for Program Development

Both external and internal sources of information should be used to create a health program. External resources include professional standards, governmental regulations, and health care literature. Internal resources include information about the characteristics, health status, health needs, and resources of the individual camp community. Table 4.1 lists resources of standards and guidelines that may be useful for the camp nurse.

Table 4.1 **Standards and Guidelines Useful in Developing Camp Health Programs**

Camping Related

Standards for Day and Resident Camps, American Camping Association

Standards for Conference and Retreat Centers, American Camping Association

Medical Guidelines for Day Camps and Residential Camps, American Academy of Pediatrics

State youth camping regulations

Nursing Related

Standards of Clinical Nursing Practice, American Nurses Association

Standards for Organized Nursing Services, American Nurses Association

Guidelines for a Model School Nursing Services Program, National Association of School Nurses

Health Related

Federal and state OSHA regulations

Healthy People 2000: National Health Promotion and Disease Prevention, Objectives, Department of Health and Human Services

Health Communities 2000: Model Standards, American Public Health Association

Caring for Our Children: National Health and Safety Performance Standards, American Public Health Association and American Academy of Pediatrics

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External Resources

Professional Camping Standards. Professional standards are a source of information about the scope and nature of health services and professional practices within the camp. The American Camping Association (ACA) (1993) and the American Academy of Pediatrics (AAP) (1991) have written standards for health care in camps. Both sets of standards focus on minimal requirements for health services. The AAP standards are less comprehensive than are the ACA standards and mirror the major emphases of ACA standards.

Appendix A outlines areas of health care specifically addressed in ACA standards. The accreditation of a camp by the American Camping Association is an important way for the public to know that a camp meets basic health and safety criteria. The camp must meet the health standards (the *E* standards) as well as others, to achieve accreditation. It is the camp nurse's responsibility to be aware of the standards, incorporate them into the health program, and work with the camp director and staff to comply with standards during the camp season.

All other areas of the American Camping Association's *Standards for Day and Resident Camps* (1993) also contain requirements related to health and safety. Camp staff and even camp directors may not recognize a direct connection between many standards and the camp health program; however, the camp nurse should review ACA standards in all areas. Primary prevention and health promotion measures are contained within many standards. Advocating for and adhering to ACA standards are part of the educator, manager, and collaborator roles of the camp nurse.

Professional Nursing Standards. There are no nursing practice or nursing service standards specifically written for camp settings. Separate standards for specialty areas of nursing practice, including school nursing, community health nursing, psychiatric nursing, college health, etc., have been replaced by the *Standards of Clinical Nursing Practice* (American Nurses Association 1991). These standards provide the basis for standards of care and standards of professional performance for registered nurses in camp settings. The ANA standards of care cover assessment, diagnosis, outcome identification, planning, implementation, and evaluation in delivery of nursing care. The ANA standards of professional performance for nurses focus on all of the following nursing functions and responsibilities:

- Evaluating quality of nursing and health care
- Maintaining current practice knowledge
- Contributing to professional development of colleagues and others
- Making ethical decisions

- Collaborating with clients and others
- Using research findings in practice
- Considering safety, effectiveness, and cost in client care

As described by the American Nurses Association (1991), nursing standards are authoritative statements describing the responsibilities for which professional nurses are accountable. They reflect the values and priorities of the nursing profession. These standards should be used to give direction for professional practice and provide a framework for evaluation of practice in camp settings. Specific responsibilities and the nature of health care, which vary from camp to camp, are not addressed in these documents. However, the professional nurse's accountability for practicing in accordance with the *Standards of Clinical Nursing Practice* (American Nurses Association 1991) remains constant across all practice settings. Other professional nursing standards and guidelines that might be useful to camp nurses include *Standards for Organized Nursing Services* (American Nurses Association 1988) and *Guidelines for a Model School Nursing Services Program* (National Association of School Nurses 1990).

Guidelines from Other Professional Groups. Several other groups, including Girl Scouts of the USA and Camp Fire Boys and Girls, have developed guidelines for health services within their camping programs. Nurses in camps sponsored by youth organizations or agencies should inquire about camping standards or guidelines specific to the organization.

Some organizations serving individuals with special health needs also provide guidelines for camping and/or camp health services. The American Diabetes Association, the National Easter Seal Society, and the American Lung Association are resources for camps serving individuals with special needs.

Legal and Regulatory Guidelines. External requirements for camp health programs include state regulations, local health department requirements, and state and federal OSHA regulations. Adhering to external governmental requirements is the primary responsibility of the camp director, while the nurse assists in their implementation. In order for the nurse to collaborate with the camp director, she should have appropriate information about those requirements that directly affect the health of the community, including food service and sanitation requirements.

The nurse and camp administrator share responsibility for incorporating state and federal OSHA requirements into the health program for staff. Education about bloodborne pathogens, including hepatitis B and the HIV virus, and measures to prevent their transmission are mandated by law and must be addressed in all camps. Worker's compensation guidelines also must be included in the camp health program.

Health Care Literature. Books, journal articles, and other publications provide important facts to use in devising health programs. Very little exists on health care in camps, but information is readily available about the health needs of children, adults, and individuals with special needs. Principles for control of injury and communicable disease are especially important in camp health care. The nurse should rely heavily on professional nursing and health care literature to provide the scientific base for camp health care.

National Health Objectives. One excellent resource to help identify the essential elements of the camp health program is the set of health objectives established for America in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (U.S. Department of Health and Human Services 1990). This document outlines the major health goals for various age groups and special populations within our nation. These national priorities form the criteria for federally funded research and health services. They identify goals for preventing the major health problems of healthy and chronically ill individuals, as well as for promoting health among all segments of the population. Most camp directors and many camp health care providers are not aware of these objectives. They should be used as a major source when determining the scope of camp health services.

Internal Sources for Community Assessment

The camp community and its members are the internal sources of information necessary for developing the camp health program. Community assessment, sometimes referred to as community analysis, identifies resources and problems within the community (Anderson and McFarlane 1988; Christensen and Kenney 1990; Higgs and Gustafson 1985; Stanhope and Lancaster 1992). It also provides the foundation for setting program priorities and goals. The camp community should be assessed continually, and each nurse affiliated with the camp should contribute to the analysis.

In most camps, it is not necessary for assessment to be complicated or time consuming. Professional nurses have the knowledge that allows them to review aspects of the camp as a community when they first arrive. However, it is important to make sure the assessment process is *systematic*. Many individual factors within a camp affect health. They comprise five main components of community assessment (Haglund, Weisbrod, and Bracht 1990). Each of these components should be considered when creating the health program. The components of camp community assessment are summarized below.

Components of Camp Community Assessment

Community Characteristics

History
Geographic boundaries, features
Environmental/climate factors
Geographic/social isolation
Organizational/political structure
Interpersonal communication networks
Power structure
Program emphasis/specialization
Session length

Member characteristics

Socioeconomic background
Cultural background
Key leaders and leadership style
Groups within the community

Values/cultural expectations about

Food patterns
Child rearing/discipline
Play/recreation
Education
Gender roles
Norms
Traditions
Beliefs about health/illness

Health Status

What is the general state of health of community members?
How many members have chronic health problems or disability?
What are the indicators of health status?

Health Risks

What are the health risks indicated by:
- Findings from previous health screening?
- Previous health logs/log summaries?
- Insurance, incident/injury reports?
- Health program annual evaluation?

Community Health Resources

What is the camp community's commitment to prevention and health promotion?
What is the extent of existing health program?
What is the level of staff involvement in health program?
What health care facilities, supplies and equipment are available in camp?
What health care services are available in nearest town?

Special Group Needs

What community groups might have unique health needs/problems?
How can group needs be identified?

Community Characteristics. A general profile of the camp community should include the characteristics of both the community and its members. Several approaches used in traditional community assessment can be used in camps. These techniques include secondary analysis, windshield surveys, informant interviews, and participant observation (Christensen and Kenney 1990).

Secondary analysis is the process of reviewing written documents from the community. Camps usually have materials such as a staff manual, a health care plan, and policies and procedures that can be examined. A written philosophy and purpose of the camp is especially helpful in understanding the values, traditions, and norms that will be observed over the summer.

Windshield surveys are comprehensive visual surveys of the community from a car. At camp, a walking tour best accomplishes this observation of facilities, geographic boundaries, and natural resources. Viewing the camp with and without campers, seeing the kitchen in operation, watching vehicles going through camp, and observing all other activities and routines of daily camp life are sources of information for the camp nurse.

Key informants are those individuals within a community who are most likely to have information about how the community really works. Administrators or staff members who have been with the camp several seasons can be key informants. Formal or informal discussion with these individuals can reveal their perceptions about the major communication, leadership, power, and organizational systems within the camp. Informant interviews can be very important in finding out how the camp philosophy is actually put into action and how seasoned staff perceive the strengths and shortcomings of the existing health program.

Participant observation involves observations within social settings. As a member of the community, the nurse sees all the social and political systems of the camp in operation. This allows the nurse to see the way things work (or don't work) in camp. For example, as a participant observer, the nurse may see that many counselors are excellent health role models, even if there is no formal, written health promotion program in place. Observing and participating in activities and events that are camp traditions are another source of practical information.

Constructed surveys also are used in community assessment. This is a more formal technique involving structured questionnaires or interviews. This approach can be time-consuming and is not frequently used within individual camps.

Health Status of Community Members. In camp communities, information about the general health of community members is not as difficult to obtain as it is in traditional communities. Camp directors usually know if their camp serves healthy individuals and if they serve campers with disabilities. Socioeconomic background also affects health status. Campers from low income families often have not had regular access to health care services and may have more existing health problems or needs than do campers from higher income groups.

Both review of camp documents and direct observation can help validate notions about the general health status of community members. Notes from arrival screening in previous summers are good sources. For example, in a camp that serves *healthy* children, screening records may indicate that many campers brought prescription medications with them to camp. This should alert the nurse to healthy campers with health care needs that must be addressed. Health history forms for campers and staff should be available at the opening of camp; they can and should be reviewed before camp and throughout camp as needed. Reviewing these forms is another means of assessing the general health of the community members. Professional literature also provides clues to the general state of health of community members. For example, if a camp serves many children with asthma, the nurse should prepare before camp for the kinds of health needs individuals with asthma may have.

Health Risks and Special Group Needs. Patterns and trends in health problems during previous summers are the most significant source of information about health risks in the camp community. Ideally. written summaries of the incidences of illnesses and injuries should be kept for each session and each season at camp. The nurse should prepare these during the camp season. However, many camps do not have this type of system in place. Until a system can be established, previous health logs, insurance reports, and incident reports should be examined. Often, when the nurse reviews these records, they reveal commonly occurring problems. Suggestions for setting up injury and illness monitoring systems are found in chapter thirteen. Participant observation and professional literature also provide data about health risks within the camp and those specific to groups served by the camp.

Community Health Resources. Resources for health care at camp include both physical and human resources. Physical resources such as a health center facility, supplies, equipment, emergency transportation, telephone, and similar items are important. But, the willingness of camp staff to make health a priority and take an active role in health maintenance and promotion are equally, if not more, important. An assessment of the level of commitment to health by staff and administrators is a critical aspect of community assessment. It should incorporate all available techniques for information gathering. A health plan already in place provides a good foundation for further health program development. Availability of good secondary and/or tertiary care facilities (emergency clinics, hospitals, medical centers) in close proximity is also an asset because it allows resources to be used for primary prevention and health promotion in camp.

Putting the Program Together

The information collected from external sources and community assessment is used to develop a plan for health care in the camp community. Information should be grouped and clustered so that patterns emerge and strengths, problems, and needs can be identified. Setting priorities and goals should be the next step. At this point, it will become clear whether the needs and resources of the community will support a comprehensive health program that includes primary prevention and health promotion, or whether management of illnesses and injuries as they arise will be the extent of the health services provided for the time being.

Developing strategies and plans to implement and evaluate the health program will require a collaborative effort by the nurse, the camp director, and camp staff over several seasons. Creating a written health plan is essential to maintain consistency in the health program from season to season and to communicate clearly to everyone in the camp community the health goals and how they will be attained. The types of health services and responsibilities of camp staff for those services are the focus of the written plan as described in the American Camping Association's standards for accreditation of camps. Components of a written health plan that meet the criteria in ACA standards are described in chapter five.

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CHAPTER 5

The Camp Health Program and the Written Health Plan

Kris Miller Lishner

The camp "health program" and the "written health care plan" are two terms often used interchangeably. They do overlap in some ways, but they are different in many aspects. The health program is all the components and processes involved in camp health. These include: assessment of community and individual needs; setting goals; creating strategies to accomplish the goals; developing a structure for health care delivery that includes policies, guidelines, and facilities; and evaluating the quality of the health program and health outcomes. The health program is a systematic process that requires the involvement of the entire camp community at some level. Not all camps have an organized process for developing and monitoring their health program, but all have some method for delivering health care.

The health plan, by contrast, is a written document that describes how health care is delivered in camp. It should include concrete details concerning the who, what, when, where, and how of camp health service. The health plan document should describe or summarize the health program, but it may not fully reflect the dynamic nature of the health program as it responds to individual health needs and changes within the camp.

Components of the Health Program

Assessment

Assessment of community and individual characteristics and needs is the most basic component of the camp health program. This process was outlined in chapter four. The information obtained through ongoing assessment becomes the foundation for the rest of the camp health program.

Health Program Goals

The development of program goals or objectives is another aspect of program development. Not all camps have defined goals for their health program. Goals may be implied through the health services provided or the lifestyles encouraged in camp activities. There are advantages to developing written goals for the health program. The following list is a set of example health goals and their advantages:

1. Stated health goals tell everyone associated with the camp (parents, staff, camp sponsors) what the camp is trying to achieve for individual and community health.
   Example: A health goal that stresses the importance of health promotion and prevention of illness/injury should lead staff and parents to expect more than emergency care from camp health services.
2. Stated health goals provide direction for health services and resources the camp offers.
   Example: A health goal of providing adult role models who demonstrate good personal health habits suggests that the camp should have a staff education component that teaches staff about good personal health habits and how to model them.
3. Stated health goals can be helpful in making decisions in other areas of camp program and activities.
   Example: Would allowing bunge jumping as an activity be consistent with camp health goals that support minimizing physical risk-taking among children?

Health program goals can be limited to just a few broad goals or can consist of many specific objectives for each part of the health program. Some camps may want to use a management-by-objectives approach with their camp health program. Whatever goals are developed must be consistent with the camp's philosophy and purposes and should arise from the needs and characteristics of the camp identified in the community assessment. Some examples of the variety of goals in a health program are included in the following list:

- A camp that serves low income children who have limited access to health care includes a goal of making referrals for all health problems identified while the child is at camp.
- A day camp in a suburban area decides to limit its health goals to providing a safe environment, good health role models, and early recognition and referral of illness and injury.
- A private camp includes a goal of providing campers with chronic health problems or special needs opportunities to participate in all camp activities to the fullest extent possible.
- A residential camp that has six to eight week sessions includes a goal of helping children develop stress management techniques and substance abuse resistance skills as part of the camp activity program.
- A camp that specializes in competitive sports includes a goal of assuring that all campers participate in appropriate warm-up exercises before sports activities.

Program Implementation — Fitting the Components Together

The pieces or components that make up the health program will differ from camp to camp, reflecting individual camp needs. The pieces might include appropriate combinations of all levels of prevention (primary, secondary, and tertiary), along with acute care for existing health problems (see chapter two). Some camps have comprehensive programs that include all of these, while other camps limit their health programs to acute care or emergency treatment of illness and injury.

In order to implement the health program the nurse must consider health education (chapter eleven), environmental management (chapter thirteen), control of communicable disease and injuries (chapter twelve), development of policies and guidelines for delivery of all levels of health care, provision of health care facilities and supplies (chapter six), and direct management of individual health problems by a qualified health care provider (chapter seven). Issues to consider in developing the management structure needed for the health program (policies, procedures, and guidelines) are discussed later in this chapter in the sections on developing the written health plan.

Evaluating the Health Program

Program evaluation is the most neglected aspect of camp health care. Few camps have devoted attention to systematic examination of health outcomes or the quality of the health program in place. Quality assurance in delivery of camp health services is in its infancy.

Many camps have not taken the time nor had the resources to consider ways to evaluate the camp health program. Like many other aspects of camp health, evaluation is a developmental process that may take several seasons to put into place. This process will continue to change over time as the camp and the health program change. The nurse and camp administrators will need to work together to design an approach to evaluation that is useful and practical for the particular camp.

The Nurse's Evaluation

Some camps ask the nurse to write a summary or report at the end of the season that is evaluative in nature. This can be helpful in planning for the next season and introducing a new camp nurse to the camp health program. It is important for the nurse to identify strengths as well as problems within the health program. This type of evaluation has some serious limitations, however. It usually reflects the personal viewpoint or opinions of one individual. Unless there are guidelines regarding what should be included in the nurse's final report, it may focus only on issues the nurse thought were problematic. When evaluation of the health program is limited to a summary or report by the nurse, it is especially important that comments be obtained using a systematic list of relevant areas. An example of such a list is included in the box below.

Areas for Inclusion in the Nurse's Evaluation

Facilities and equipment	Health center building Health equipment Health supplies
Prevention and health promotion efforts	Staff support and participation Counselors Activity staff (specific areas may be included) Kitchen staff Office staff Program director Administrative staff, including camp director

continued

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Areas for Inclusion in the Nurse's Evaluation (continued)

Prevention and health promotion efforts (continued)	Effectiveness of staff as role models for good health practices Staff supervision of camper health Sanitation procedures throughout camp Management of environmental hazards Injury control procedures Use of universal precautions
Management of the health program	Adequacy of nurse job description The written health care plan Standing orders Health screening on arrival Written policies Management of medications Use of first aid procedures Bloodborne pathogens plan Emergency procedures Implementation of Americans With Disabilities Act guidelines
Recordkeeping	Individual health records Health center log Medication records Injury/incident reports Illness/injury summaries Insurance forms
Relationships/interactions with	Campers Parents Camp physician Camper physicians/other health care providers
Suggestions on additional ways to reduce	Illnesses Injuries
Recommendations for next year	

With some effort, other types of formal (structured and/or written) and informal (unstructured and/or verbal) evaluation of the health program can be used in addition to the nurse's final report. These information sources do not have to be sophisticated. Even simple sources are important in collecting a wider variety of perspectives on the effectiveness of the health program. One way to organize the collection of evaluative information is to use the health program

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objectives. Ideally, several different sources can be used to obtain data about each health program goal, and an example of an evaluation plan that acquires information about each health goal from more than one source is included in Appendix Q.

Other Sources of Information for Program Evaluation

Performance appraisals based on job descriptions provide indirect data about the quality of the health program the nurse and other staff implemented during a season. Counseling and activity staff job descriptions and performance appraisals can include health-related items (supervision of camper health, injury prevention, role modeling). A pattern of problems or strengths in staff performance in health areas might suggest areas for improvement or well-earned recognition in the health program.

Camps also may want to have all camp staff participate in a formal evaluation of the health program. A form can be created for that purpose, or staff can be asked to write a brief paragraph about their perceptions of the strengths and limitations of the program. Informal feedback for evaluation of the health program can be used to supplement formal evaluations and can be obtained by discussion or specific questions at staff meetings.

Campers and their parents also can be asked to comment on the camp health program. The best way to obtain campers' opinions is to have informal discussions with them at the end of the session. Parents can be asked both formally and informally for their evaluations. For example, specific questions about the health program can be included with any camp evaluations parents are asked to complete.

The camp physician also can be asked to provide feedback on his or her experiences with the camp health program. Informal approaches that involve brief meetings or telephone conversations may be effective when there are time constraints. When the relationship between camp and physician has been strained or difficult for some reason, a written evaluation may better allow free expression of the physician's assessment of the situation. Questions to ask the physician might include:

- Were referrals made by the camp appropriate?
- Were your instructions/recommendations followed by camp staff?
- Was adequate information about the individuals you saw provided by the camp?
- Was the communication between your office and camp staff clear and organized?

- Was paperwork and reimbursement handled efficiently?
- Did you feel comfortable with health decision-making by camp staff, health supervision of campers, and early recognition of developing problems?

In addition to formal and informal evaluations, health program records are an important source of evaluative information. For instance, injury and illness summaries reveal patterns and trends that can be analyzed and related to prevention efforts. Also, insurance claim forms and bills from health care providers, hospitals, and pharmacies reveal information about the quality and success of the health program. The nurse and camp administrators should remember, however, that evaluation based on illness and injury trends or health costs has limitations. This information should always be combined with other sources of data because these trends can be influenced by factors other than the quality of the health program, such as general health care cost inflation and environmental fluctuations (flooding, heat waves, etc.)

The Written Health Care Plan

Camps should have a written health care plan that summarizes all aspects of their health program together in a single document. The health care plan provides a blueprint or organizational design for the health program. The written plan is essential in ensuring continuity in implementation of the program from year to year and provides a reference point for evaluation and change in the program.

The written plan should provide an overview of all components of the health program—prevention, health promotion, acute care. Each section of the plan should provide enough detail to indicate the general nature of what that part of the health program consists of, who is responsible for getting it done, and, in some instances, guidance about timing and location. Information in the written health plan should be a summary, not as detailed and specific as the policies and procedures staff need for direction in carrying out individual parts of the health program.

American Camping Association (1993) accreditation standards for camps require a written health care plan that is reviewed annually by the camp administration and the camp's health staff. The standard includes areas that *must* be covered in the written plan. A list of these areas is illustrated in figure 5.1. These sections represent *minimum* requirements and focus almost entirely on provision of health care services. The areas listed in the standard do not specifically include prevention or health promotion. For camps that do not have an existing written health plan, the ACA (1993) standard provides an appropriate starting point in

developing one. The appendixes of the standards book (American Camping Association 1993) contain a document called the "Sample Outline of Health Care Plan" that will be useful to nurses and others writing a plan that will meet the requirements of the ACA standard. A copy of the sample outline is in Appendix R.

Figure 5.1 **General Guidelines in the Written Health Plan Required to Meet ACA Standards**

Responsibilities and authority of camp health manager and all other staff providing health care (including first aid)

General routines for camp health care and sanitation

Record keeping

Provision of supplies and equipment

Relationships and agreements with medical personnel, hospitals, and providers of emergency care

Camps should expand their written health care plan to include areas *not* required by ACA standards as their resources allow. Examples of important additional sections to include are health program goals, an overview of the communicable disease and injury control programs, prevention and health promotion programs, and the health program evaluation process.

Health Program Policies and Procedures

In addition to the written health plan, camps should develop specific, detailed policies, procedures, or guidelines for all aspects of the health program. These documents provide the essential information and directions each person responsible for some aspect of the health program needs to fulfill his or her responsibilities. Policies, procedures, and guidelines provide the criteria against which individual staff behavior and judgment concerning health issues are measured. They can be useful in staff training as a way of reinforcing the instruction staff should receive about the health program and their role in it.

Nurses who have worked in other health care facilities know the value of policy and procedure manuals, especially for those nurses new to a facility. That same level of detail and documentation provides important support and direction needed by staff in camp health care. Camp administrators and other staff may not have experience with these types of written policies and procedures. Some may question the value of the paperwork. However, the nurse should strongly urge

that this documentation be maintained based on the high turnover in health care and other staff in camps, the seasonal nature of most camps, and the critical importance of health-related decisions made in camp.

The National Association for the Education of Young Children (NAEYC), the organization for professionals involved in preschool and day care centers, developed standards for out-of-home care that affect millions of children each year. Over the years, they have had considerable experience with writing health care policies and procedures for these settings. They provide some helpful advice on how to write effective guidelines (Kendrick, Kaufman, and Messenger 1991). Their recommendations are included among those in the list below.

- Have staff, health care providers, and, in some situations, parents review a draft of the policy to be sure it is understandable and these individuals are able to carry it out
- Develop a system to inform everyone when revisions are made in health policies
- At the end of each policy, include the date the policy was developed or when it goes into effect
- Make sure each policy answers each of the following questions:

  a. What should be done?

  b. Why should it be done (rationale)?

  c. Who is responsible?

  d. What is the process? (How should it be done?)

Health care policies should reflect recommendations of staff, parents, and health experts. They should be specific and detailed and clearly define responsibilities.

Not all camps or health care facilities include rationale with each policy or procedure. However, in many cases, including rationale can reinforce the importance of the policy. For staff or parents who are not aware of the reason for a policy, rationale may increase the likelihood that they will adhere to it.

References

American Camping Association. 1993. *Standards for day and resident camps*. Martinsville, IN: American Camping Association.

Kendrick, A., Kaufmann, R., and Messenger, K., 1991. *Healthy young children: A Manual for programs*. Washington, DC: National Association for the education of Young Children.

CHAPTER 6

Managing the Health Center

Kris Miller Lishner

Every camp needs an area that is designated the camp health center. Even though most health promotion and prevention activities occur in the living units and program areas rather than in the health center, the center serves as the base of operations for the nurse, as well as a central location for health resources, information, and care of illness or injury. Campers and staff should feel comfortable using the health center as a place where they can get help meeting their physical, emotional, and social needs, as well as becoming and staying healthy.

What's In a Name?

The name of the location or building in camp that serves as the operations center for health care may seem relatively insignificant, however, that name conveys some important information about the health program, of which the health facility is only a part. Whether it is a tent, an area of the camp office, or a separate building, camps that call their health care facility the "infirmary" or the "sick room" or the "first aid center" are delivering the message that treatment of illness and injury are the focus of their health program.

The term "infirmary" is a very old one that has historical roots in the middle ages. Infirmaries were established as that part of monasteries and other religious organizations for care of the sick and infirm (Bachmeyer and Hartman 1943). During the 1800s many hospitals in America were originally called infirmaries.

An infirmary was included as a part of some of the earliest resident camps established during this time. As with many other camp customs and traditions, the name stuck.

Used as a descriptive term for camp health care facilities or services, "infirmary" is outdated and potentially detrimental. To many campers, staff, and parents this word suggests illness, pain, and inactivity. Camps need names for their health care facilities that convey the true focus of their health program. For some, a "First Aid Station" might reflect the limits of the health care they are able to provide. In camps with health programs that involve health promotion, all levels of prevention, and acute care, the term "Health Center" or something that conveys more than illness care is more appropriate.

Physical Facilities

The physical facilities needed to manage the health program and provide health services at camp will depend on the scope of the health program, the size of the camp, and the resources the camp has available. Sophisticated or complex facilities are not needed to provide effective health programs in most camps. Specific decisions about physical facilities should be based on community assessment information and the goals for the health program. For example, some camps that serve groups with severe physical limitations or chronic illnesses requiring specialized treatment may need a building with a backup power supply for respiratory or other essential equipment.

ACA Standards

A few basic elements of the physical facilities for health care should be provided, regardless of camp characteristics. American Camping Association (1993) standards require *all camps* to provide some type of sheltered area for first aid and emergency treatment that includes at least the following:

- Protection from the elements (rain, wind, sun, etc.)
- Water for drinking and cleaning
- A toilet
- A first aid and dispensary area

In addition, ACA (1993) standards require the following (except for day, trip, and travel camps):

- One bed per 50 campers
- Isolation, quiet and privacy

Location and Use of Internal Space

Finding a good location for the health center sometimes can be difficult. A central location that is easily accessible from most parts of camp but still relatively quiet and away from heavily traveled areas is best. Inpatients may need quiet and rest for recovery. Nurses who reside in the health center also deserve some separation from camp activities, at least some of the time.

Use of space inside the health center requires careful consideration. The patient and nurse need privacy during assessment or treatment. Waiting and treatment areas should be far enough apart that conversations are not overheard and the patient is not visible to others. Sometimes this can be accomplished by locating a waiting area on a covered porch or outside and adjacent to the health center. Use of curtains or screens also may be helpful.

Providing isolation beds for inpatients may take some creative use of space. It's important to isolate individuals with potentially serious communicable illnesses to prevent their rapid spread. A way to set up immediate isolation for an individual always must be available. Some camps arrange for additional patient beds in other buildings if unusual situations arise, such as an outbreak of gastroenteritis. It may be wise to have more than one backup plan for isolation as inpatient patterns in the health center change. The more limited the space available in the health center, the more resourceful the nurse must be in finding ways to secure privacy and allow for potential isolation.

Other Considerations in the Health Center Environment

Maximum visibility and lighting must be considered when arranging space, furniture, and equipment in the health center treatment area. Accurate observation of physical characteristics, signs, and symptoms depend on full visibility and good lighting. Whenever possible, a room with good natural lighting should be selected as the treatment area. When the health center building has inadequate lighting, additional local lighting (such as an overhead light fixture and a portable lamp) is a sound investment for most camps.

A resource area in the health center or staff retreat area is an appropriate consideration for camps with comprehensive health programs that include health promotion and primary prevention. Educational materials about common health concerns of staff can be kept on shelves or a small table in the health center. Self help books, pamphlets and materials on child and adolescent development, communication skills, nutrition, and other subjects can be kept where they are readily accessible. Other potential additions to the resource area in the health center include an empty metered dose inhaler and an EpiPen® (without needle) for staff to handle and practice using. Staff usually are most interested in health

information that concerns them personally. Having information available, with no pressure and no questions asked, also often increases staff willingness to see and use the health center as a resource for camper health.

Many educational materials are available free of charge from state and local health departments, service organizations, and support groups. Materials at different sophistication and reading levels for campers and staff are needed. Nurses may want to set up a simple checkout system for materials that are available in limited supply. Access to some educational materials for staff, such as information about sexually transmitted diseases, contraception, or alcohol and drug abuse prevention, may need to be more tightly controlled.

Another thing to consider about the health center is its ambience or atmosphere. It should be friendly and receptive. Use of colorful posters, soft music, plants, flowers and other natural items help campers and staff feel welcome. If the health center is to be used effectively, the facility and health staff must be perceived as open and accepting.

Some camp administrators become concerned that when the health center is comfortable and inviting, it will be used as a social gathering place for staff or by campers who don't want to participate in activities. Establishing limits on use of the health center for socialization may be warranted. But frequent use of the health center and excessive social contact with the health staff may be an indication that some individuals have needs that are not being met through other camp activities. Further assessment and follow up is important in these situations.

Equipment and Supplies

Equipment for the Health Center

Suggested basic equipment for a health center staffed by a registered nurse, in a resident camp serving groups composed primarily of healthy children, is included in the box below. This list should be supplemented with additional emergency equipment in large camps, those located long distances from emergency facilities, and those serving campers with diverse or special health needs. Many of the items on this list are specialized equipment for professional health care providers and should not be used by first aiders or untrained staff. For example, the use of an otoscope, blood pressure cuff, and stethoscope require training.

Suggested Minimum Equipment for the Health Center

Telephone or other emergency communication
Emergency vehicle for transportation
CPR mask
Airways/resusitubes—adult and child size; infant size if relevant
Beds with waterproof mattress or mattress covers
Thermometers
Stethoscope
Blood pressure cuff—child and adult size
Otoscope
Sharps container (2 liter plastic soft drink bottles can be used in some states; check with state OSHA office)
Marked box or can for disposing of contaminated waste
Refrigerator with a lock for storing medications that must be refrigerated; or, a box with a lock that can be used to store medications within a refrigerator that cannot be locked
Locking cabinet or box for medications
Locking file or storage box for health records
Flashlight/batteries
Portable lamp
Bandage scissors
Splinter forceps
Table for treatment/examination
Inflatable splints
Stove or hot plate
Foot or similar basin
Emesis basin
Hemostat
Bulb syringe
Bathroom scales
Heating pad
Fan (in warm climates)
Small wire cutters (for fish hooks and orthodontic brace wires)

At the beginning of the camp season, all equipment should be carefully cleaned and examined to make sure it is safe and appropriate for use. Often the nurse will find pieces of old equipment that are no longer useable but still being kept. This type of equipment should be disposed of because it creates a potential hazard if used inappropriately by an uninformed individual in an emergency (primary prevention).

Elaborate or sophisticated equipment usually is not needed, unless the camp serves groups with highly diverse or specialized needs. Cost is a major concern for camps trying to equip a health center appropriately. The most economical approach is to start with minimal equipment, adapt as much as possible, and plan major purchases carefully in response to need documented by use patterns over time.

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It is easier to maintain equipment in good working order when it receives good care between camp seasons. Large items stored in closed buildings over the winter should be covered to protect from insects and rodents. Small items should be wrapped or covered to prevent water damage, then stored in a safe place. Items that could be damaged by temperature extremes (thermometers, batteries, etc.) should be stored with other perishables when the camp season is over.

Supplies for the Health Center

Each season, the nurse will be involved in restocking the health center with supplies. Like equipment, supplies can represent a major expense for the camp. Generally, camps should stock only basic, frequently used supplies and purchase less frequently used items when specifically needed. A system should be developed for purchasing and maintaining supplies as part of health center management. Basic elements of a system for managing health center supplies are listed below:

- Make an inventory list of all supplies
- Track and tally supply use by session or season
- Dispose of outdated or damaged supplies
- Purchase in large (but not excessive) quantities to reduce cost
- Consider joint orders with other camps
- Use wholesalers or discount sources, if possible
- Put date of purchase on all new supplies
- Store in containers to reduce loss due to environment and wildlife

The first step in this system is to create an inventory of existing supplies. A list of suggested basic health center supplies is included in table 6.1. Each season, the type and amount of all supplies used should be tallied as a basis for future purchasing. If, in the case of some camps, different types of campers attend various sessions, supply use should be tracked by session because supply use varies by session. For example, supplies used in the health center might be different during a session for older adults than during a session for diabetic campers.

As with health center equipment, existing supplies should be checked against the inventory at the beginning of each camp season. Supplies that are outdated or damaged should be discarded. In order to assess their quality and usability, each new purchase should have the purchase date written on the item, box, or container. This is especially important with sterile supplies, medications, and cleaning/disinfectant solutions.

Table 6.1 **Recommended Basic Supplies for the Health Center**

General Supplies
Suture removal kit
Disposable plastic medicine cups
1 cc, 3 cc, 5 cc syringes with needles
First aid kits for trips and activity areas
Ice packs (ice bag, or ice cubes in plastic bag)
Paper cups and towels
Tourniquet
Latex disposable gloves
Face shield for health care provider working with body fluids
Sewing needles
Assorted sizes elastic bandages (2", 3")
Tongue depressors
Moleskin
Disinfectant wipes
Rubbing alcohol
Cleaning solution for surfaces exposed to body fluids

Skin antiseptic, skin wound cleanser, and skin wound protectants (American Pharmaceutical Association 1986):
Povidone-iodine solution
Benzalkonium chloride 1:750 solution

Sterile Supplies and Dressing Material
Stretch/conforming gauze bandage, 2", 3", 4"
Tapes:
- paper 1/2", 1"
- cloth/silk 1/2", 1"
- waterproof 1/2", 1"

Adhesive strips, 3/4" and 1"
Sterile and non-sterile gauze pads, 2x2, 3x3
Telfa or other non-stick dressing
Cotton-tipped swabs

Specific Medications in Camp Physician's Standing Orders (Examples):
acetaminophen
ibuprofen
calamine lotion
specific antibiotic ointment
epinephrine
emetic
specific antihistamine
specific antacid
specific athlete's foot preparation
specific antihistamine
specific decongestant
specific cough suppressant
specific topical analgesic
specific topical hydrocortisone ointment
specific eye irrigating solution

Many camps have found it much less expensive to order supplies in quantity from wholesalers. Buying band aids in boxes of fifteen hundred can cost 50% less than buying smaller boxes from a local drug store or discount store. With some supplies, however, the quantities stocked by wholesalers are in excess of camp needs. The camp director and the nurse should work together to determine the best supply sources for the camp, based on the size of the camp community and past supply use patterns. When several camps are located in the same area, they might consider joint purchasing some health supplies in very large quantities.

Regardless of the purchasing source used, supplies must be ordered or purchased *before* camp opens so they will be on hand as soon as staff begin to arrive. Part of the supply maintenance system might be to develop a minimum starting supply order at the end of each camp season that can be purchased to be on hand when camp opens again the following season.

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During the camp season, as well as when camp is closed, supplies should be stored carefully to reduce waste and damage due to moisture, insects, or rodents. Using various sizes of self-sealing plastic bags for storage usually is effective in protecting sterile and adhesive backed materials from humidity and moisture damage. Metal or heavy plastic boxes can be used to keep out the various wildlife that may attempt to set up housekeeping in some supplies. Extreme temperatures (cold and hot) can damage or inactivate certain medications and other types of supplies. These should be stored in areas appropriate for perishables.

Getting the Health Center Ready to Function

The nurse should arrive at camp before staff training begins in order to prepare the health center for health care delivery as soon as staff might need it. Very few camps provide cleaning staff for the health center. The initial, opening of season, heavy cleaning may take considerable time and effort if the building has not been open for several months. It also may need to be aired out and new homes found for insects and other animals in residence. Cleaning must be done before equipment and supplies are placed in the health center, so delaying health center set up until camp starts is not wise.

It is best for nurses to clearly establish their territory in terms of personal and private living space before camp begins. Often the nurse's living quarters are part of the health center building. When this is the case, those living quarters should be off-limits to campers and other staff at all times so the nurse has a place to call his or her own.

Establishing Policies and Procedures for Effective Use of the Health Center

Before camp, the nurse must review and make any needed revisions in policies and procedures for use of the health center. Some camps establish specific times of the day when health staff is on call to respond to the needs of anyone who walks in. The traditional approach has been to schedule "sick call" for a 30-60 minute period after each meal. During that time, everyone who needs something at the health center gathers in the waiting area. Individuals in the group may need routine medications, treatment of various illnesses or injury, information, or health counseling. In addition, camps should consider their policies regarding supervision of campers going to the health center. For example, should a staff member accompany campers to sick call or not?

The best pattern for health center use in each camp community must be assessed individually. Often, it is advantageous to schedule times of the day when health staff will be available for specific purposes in order to avoid large congregations of people at the health center immediately after meals. Specific times can be established for taking medications, other times for treating individuals, and still other times for consulting with and educating staff or campers. If this is not possible, individual appointments can be scheduled for nonacute health problems or health counseling.

When there is only one nurse in the camp community, it is essential that some type of guidelines or system be in place to locate that individual immediately when he or she is not in the health center. Many camps have special signs that are left on the health center door with the names of various places around camp. Others have a chalkboard outside the health center where the nurse's location can be written in. Some large camps are using beepers or CB radios to contact health staff when they are away from the health center. The mechanism for contacting the nurse is not nearly as important as having specific procedures for the contacting system and making sure everyone in camp knows and understands the system.

Depending on the size and nature of the camp, the number of health staff, and the type of facilities available, several other policies and procedures might be needed to ensure the most effective use of the health center. Some areas to consider for policy development include:

1. Times of the day when health staff are available in the health center
   - What are the procedures to follow to locate the nurse when no one is at the health center?
2. Persons authorized to enter the health center when health care staff are gone
   - Will building or parts of the building be locked when nurse/health staff not there?
   - Who will have a key?
   - Who can enter building/use facilities when regular staff not there?
3. Areas of the health center that are "off limits" at all times
4. Use of health center for other program activities or storage
   - Will any non-health program be conducted in the health center facility?
   - Will the facility be used for storage for other programs?
5. Checkout system for books/educational materials/first aid kits/equipment
   - What kind of paperwork/signout sheet will be used to keep track of material borrowed by campers/staff?

6. Use of bathroom by non-health care staff/campers
   - Will individuals other than health staff and inpatients have access to bathroom, bathing or other parts of the health center for personal use?
7. Use of refrigerator by non-health care staff/campers
   - Will the refrigerator be used by other staff for storage of personal items?
8. Responsibility for cleaning
   - Will health staff have responsibility for all cleaning of the health center?
9. Pets of health staff
   - Will pets of the health staff be allowed in the building? Certain parts of the building?

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American Camping Association. 1993. *Standards for day and resident camps.* Martinsville, IN: American Camping Association.

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CHAPTER 7

Managing Health Problems of Individuals within the Camp Community

Kris Miller Lishner

In the role of direct care provider, the nurse uses all phases of the nursing process in helping individuals and groups within the camp community. While nursing process is universal, there are important differences in the setting, resources, and characteristics of clients at camp. This chapter will focus on aspects of direct nursing care that may have to be adapted to different camp settings.

Health Assessment of Individual Campers and Staff

Health History and Physical Examination Information

In most camps, campers and staff are basically healthy individuals. In *all* camps, essential information about individual health status should be required from each camper and staff member on a camp-provided and standardized health

history form completed before camp. Resident camps also should obtain a record of a physical examination completed within the two years prior to the beginning of camp (American Camping Association 1993). If possible, it is wise to require the same forms for staff that are used for campers.

Resident camps can use a single form to obtain the health history, the record of the physical examination, and a signed release for treatment. Some camps require separate forms completed for each, and day camps often need only a health history form and signed release for emergency treatment. See Appendixes for sample forms for obtaining a health history, physical examination report, and authorization for treatment. Regardless of the form(s) used, the health data obtained should include enough information to allow safe and effective health care and participation in program activities while the individual is at camp. Appendix L provides a description of the basic information which should be obtained on these health forms.

It is advantageous to have health forms available for the nurse to review before campers arrive. This allows the nurse to identify campers with special health problems and make sure all necessary information about their needs are included. Having information ahead of time also enables the nurse to set aside time or plan for a more thorough assessment of these campers.

Arrival Screening

It is seldom necessary for the nurse to make a total health assessment of campers and staff unless a problem is suspected or additional information is needed about an existing health problem. Because resident camps assume a greater level of responsibility for camper health supervision than do day camps, a brief, initial health assessment should be conducted on all campers and staff when they arrive at a resident camp. In most camps this process is referred to as "screening."

American Camping Association standards (1993) require screening of all campers in resident camps within twenty-four hours of arrival at camp. However, screening should occur *as soon as possible* after campers arrive. This will allow the nurse to identify potentially communicable illnesses before they can be widely spread throughout the camp (see chapter twelve).

Screening usually gives each camper an opportunity to meet the nurse and see where the health center is located. Parents who bring their children to camp also may meet the nurse at this time. During screening the nurse can establish an initial relationship with individuals who have existing health problems that must be managed at camp. This first contact with campers and their families is important for nurses because it is a time to establish their roles as resource persons and collaborators, as well as a health care experts.

A well organized, systematic procedure for managing arrival screening can make the experience productive for the nurse and provide a positive introduction

to the camp health care system for campers. The list below summarizes the types of information to be obtained and the types of observations that should be made during screening.

1. Assess for:
   - Skin rashes or lesions
   - Athletes foot
   - Lice or nits
   - Respiratory infections
   - Eye irritation, drainage
   - Limitations in movement
   - Excessive paleness or flushing
   - Limping
   - Swelling, bruises
   - General affect, posture
2. When history, observations, or reported symptoms warrant, also assess the following:
   - Temperature
   - Lymph nodes
   - Throat
   - Ears
3. Verify information on health form, or obtain information about:
   - Contact with individuals with known communicable illnesses within past two weeks
   - Allergies
   - Medications or treatments required while at camp
   - Restrictions on activities
   - Special diets or nutritional needs
   - Any health concerns the camper/staff would like to discuss with the nurse
4. Note any changes in the individual's health status since the time the from was filled out (i.e., mononucleosis, strep)

Nurses in resident camps manage the screening process in a variety of ways. The number of campers enrolled, the number of health care providers and staff available to help, and the means of transportation to camp all affect the way screening is handled. Screening can be a hectic and sometimes confusing time because so much information and so many tasks must be managed in a short period. Often, additional health staff or other staff not usually involved in the health program must be assigned to assist with screening. The nurse must organize the process and prepare the additional staff.

Some nurses ask campers brought to camp by their parents to come to the health center for screening as soon as the camper has finished meeting the staff and getting settled into his or her unit. This allows parents to meet the nurse and the nurse to go over any relevant health information with both parents and campers. This approach can be chaotic and disorganized if several families arrive at the health center at once. When additional staff are assigned to help with screening, it provides more flexibility for the nurse in these situations.

Camps that transport groups to camp by bus sometimes arrange screening at the departure site. This approach allows the nurse a greater opportunity to talk with parents than does screening that occurs after arrival at camp. Unfortunately, few camps have the facilities necessary to conduct a thorough screening that includes full visual observation for skin lesions and existing health problems. Providing privacy during screening can be especially problematic with limited facilities. Often in these circumstances screening becomes a process of "checking in" rather than a true health assessment. Generally, screening before departure for camp should be avoided unless good facilities are available and adequate time can be allotted for assessment of each camper.

In the most common approach to screening after arrival at camp, unit living groups come together with their counselor(s) to the health center for screening. An example of a procedure for screening unit groups at the health center is outlined in the following box.

It can be beneficial to the staff, the campers, and the nurse to use other staff to help with screening. Staff can be taught how to ask campers about allergies and exposure to communicable illness, and to ask other relevant questions. They also can be shown how to observe for signs of communicable illness. Staff would be expected to refer any questionable observation or information to the nurse for final assessment. This process helps staff learn how to make relevant observations of campers, helps campers see staff as people who are concerned and knowledgeable about their health, and helps move the screening process along quickly and smoothly. Use of other staff is usually necessary to complete screening within twenty-four hours in camps with large enrollments.

A Suggested Procedure for Arrival Screening in a Resident Camp

Campers and Unit Staff	
In unit before screening	Staff explain purpose and process of screening to campers
	Staff collect *all* medications, notes from parents, or other health-related materials campers brought to camp to take to screening
	Campers dress in bathing suit, bathrobe/towel, and shoes before going to the health center
At the health center	Unit staff introduce campers to the nurse(s) and other staff helping with screening
	Unit staff give collected medications and other information to nurse
	Unit staff organize quiet activity or games among campers who are finished or waiting for screening
Nurse	
Before screening	Reviews all health forms available and notes additional information needed about individual campers
	Orients staff helping with screening to the specific screening responsibilities
	Arranges space, equipment, and supplies to allow smooth and efficient traffic flow in the health center
	Sets aside an area where individual campers can be assessed in privacy
During screening (some tasks may be delegated to other staff)	Verifies relevant information on health forms with camper
	Discusses with campers medications brought to camp and how they will be managed
	Makes relevant observations and assessments on campers
	Completes brief assessment of all questionable observations referred by staff helping with screening (never delegated)
	Makes notes about campers who should return for follow up visits for further care,routine medications, or referral and schedules follow up camper appointments

continued

A Suggested Procedure for Arrival Screening in a Resident (continued)

Nurse (continued)	
Immediately after screening	Discusses relevant camper health, treatment, or medication information with unit counselor(s)
Within 24 hours	Records screening findings on individual camper health record
	Makes follow up phone calls to parents or physicians to obtain missing information or clarify unclear/conflicting information about health problems, treatments, or medications
	Completes more in depth assessment and discussion with campers with special health needs
	Provide written follow-up of camper health needs and allergies to appropriate staff and kitchen

Special efforts should be made during screening to make sure campers are not embarrassed in front of their peers. Staff should be carefully instructed to make no verbal comments about a camper's health status in front of other campers when screening groups of campers together. The camper should be assessed by the nurse in a private area, particularly when dealing with a potential problem.

Once the screening process is completed, findings must be recorded and a follow-up done on any problems identified. Frequently, important information or signatures will be missing from some health forms. The nurse should call parents or physicians to clarify any questions, especially those involving medications and treatments. An additional health form may have to be sent to parents if they have not signed the authorization to treat.

Pre-Trip Screening

In resident camps that send campers on trips lasting three of more days, it is wise for the nurse to do a brief screening of those campers going on the trip before they leave. Any untreated obvious health problems or potentially communicable illnesses can be managed by the nurse before the camper leaves. If a problem is found that may make participation difficult or dangerous for the camper, the nurse can arrange treatment and help make plans for the camper to go on a different trip later in the session or assist in modifying trip plans to accommodate the camper.

Day Camp Check-In

Day camps usually need a "check in" for campers only on the first day of the session. Day campers will be living at home, and their parents will have primary responsibility for their health care and health-related decision making. In addition, the potential for communicable illness transmission is limited somewhat in day camps because there are fewer shared meals, and campers go home each day rather than sharing sleeping quarters with other campers.

The check in process at day camps should be much less time consuming than that in resident camps, but the process is very important and should be thorough. Each camper's health history form should be reviewed. Any medications the camper requires during the camp day should be checked and stored along with the directions for their administration. Parents should be questioned about any recent exposure to communicable illnesses, and restrictions on activities and allergies noted.

Identification of Health Problems During the Camp Session

Once screening is completed, camper and staff health problems are identified and managed as they arise. Identification of new or potential health problems in campers is a responsibility shared by the camper, the staff, and the nurse. However, the nurse is the staff member who has the education, skills, and resources to help campers and staff assume greater control over their own self-care.

During their introduction to the nurse and the health center, campers can be instructed in how to get help when they are sick or injured. They should know how to find the nurse and how to seek help from their counselor(s). Younger campers may be accustomed to their parents discerning when they are ill and obtaining treatment for them. These campers will need that same help from their counselors and the nurse while at camp. In many camps, nurses have found it wise to require that a staff member accompany ill or injured campers to the health center, rather than having campers go by themselves. The presence of the counselor can be reassuring to the camper and will allow the nurse to communicate directly with staff about the camper's problem.

When the nurse observes campers in various areas around the camp during daily activities, and goes on planned visits to each living unit, he or she has many opportunities to identify signs of illness or injury among community members. These planned visits give everyone in the unit a chance to discuss health issues informally with the nurse without making a special trip to the health center. Campers and staff also can be encouraged to use scheduled "walk in" hours at the health center to talk to the nurse about health concerns.

Treatment and Management of Individual Health Problems

Most health problems at camp are minor illnesses and injuries that can be evaluated and managed by a professional registered nurse. Figure 7.1 illustrates the categories of illnesses and injuries reported most frequently in several studies of health center visits in children's camps (Asnes et al 1974; Lishner 1986, 1988; Otto 1980; Rotman and Schmalz 1977; Schwartz 1980). The largest pieces of the pie in Figure 7.1 (respiratory infections, dermatologic problems and musculoskeletal problems) have consistently been among the most frequently reported problems. Patterns will vary from camp to camp, based on community and program characteristics, however.

Approaches to Treatment of Camper and Staff Health Problems

There are a variety of ways to manage the care of injuries and illnesses that occur at camp. Whichever approach is used must be based on the camp community assessment, the goals of the health program, and the arrangements with the physician who provides medical care for the camp. The following list identifies different ways of handling common illnesses and injuries when a registered nurse is employed on site as health care provider:

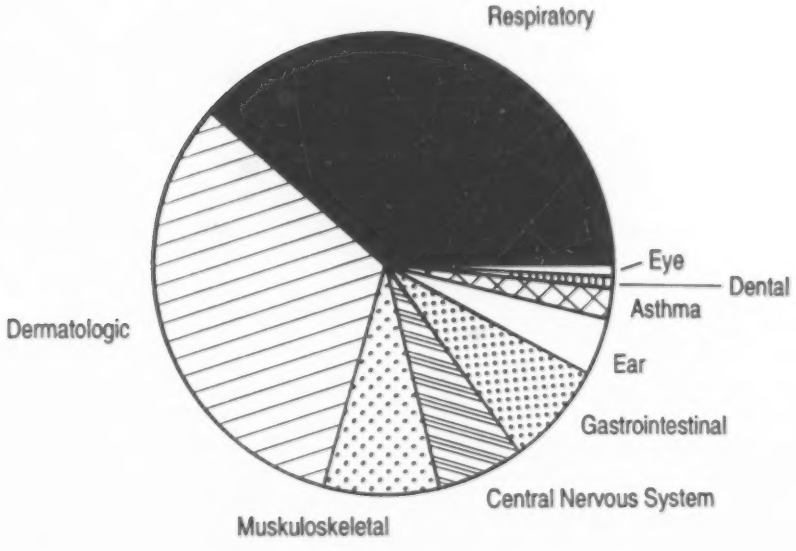
1. The camp nurse or (in camps with no licensed health staff) other camp staff manage screening and common minor illnesses or injuries using written health care procedures reviewed by a licensed physician, and refer all but the most minor injuries and illnesses to the physician.
2. The camp nurse manages common, minor illnesses and injuries according to written standing orders from the camp physician and refers anything not covered by the standing orders to a physician.
3. A nurse practitioner manages illnesses and injuries in collaboration with a local physician and refers difficult problems to the physician.
4. A licensed physician on site sees and treats all illnesses and injuries; a nurse carries out the individual written orders and provides nursing care.

The American Camping Association standards (1993) require that the following written procedures be in place in all camps (except day camps) for handling common health problems and health screening:

1. Standing orders approved annually in writing by a licensed physician, or
2. Written health care procedures reviewed annually by a licensed physician

Figure 7.1 **Most Common Illnesses and Injuries in Day and Resident Camps**

Respiratory infections	Abrasions, lacerations, rashes, splinters, blisters, contusions
Dematologic problems	Colds, sore throats, coughs
Musculoskeletal problems	Strains, sprains
Central nervous system (CNS) symptoms	Headaches, dizziness
Gastrointestinal problems	Stomach ache, vomiting, diarrhea,
Ear problems	External and internal otitis
Asthma/respiratory difficulty	
Dental problems	Toothaches, broken braces
Eye problems	Infections, foreign bodies



Use of Standing Orders

According to ACA (1993) "standing orders" generally refer to specific treatments that are implemented by licensed personnel. Standing orders for the nurse might include protocols (including over-the-counter or prescription medications) for reactions to bee stings, head injuries, vomiting, headaches, and similar types of emergencies or common, minor illnesses.

Written health care procedures are less specific than standing orders and may include general first aid guidelines, procedures for health screening, and symptoms that should be referred to the physician. These general written health care procedures are more appropriate for use by unlicensed personnel than are standing orders.

The legality of standing orders and how they can be used varies from state to state. Their status in the state where the camp is located should be checked with the state board of nursing before standing orders are used. In addition, even in states where standing orders are legal, some individual physicians will not authorize or sign standing orders for camps.

The camp physician takes considerable professional risk when authorizing standing orders for the camp nurse. The physician should be extremely careful in examining the qualifications, experience, and background of the individual(s) who will be authorized to carry out these orders. The camp and the nurse also should take implementation of standing orders very seriously. The camp should make every effort to be sure it has hired a nurse who is legally qualified and professionally capable of the decisions and judgments required to carry out those orders. The individual nurse should carefully examine each aspect of the standing orders to make sure he or she feels able to fully implement them in the specific circumstances of the individual camp setting.

Often, the nurse will be asked to assist in the development or revision of the camp's written standing orders before they undergo annual review and signature by the camp physician. This provides an opportunity for the nurse to evaluate whether or not the orders are appropriate and realistic for him or her and the camp. Conditions that should be covered in the standing orders include those listed in figure 7.1. as well as potential emergencies, such as anaphylaxis. Formats used for camp standing orders vary greatly. Generally, the more complete and specific the standing orders for each condition covered are, the better. One good model for writing or revising standing orders is provided by the American Academy of Pediatrics (1993) in *School Health: Policy and Practice,* Table 26. Other useful examples can be found in Figures 1-1 and 1-2 in *The New School Health Handbook* by Jerry Newton (1989).

Nursing Management of Camper and Staff Health Problems

Individual assessment of a camper or staff member provides the data base from which the nurse decides what type of care is needed. The majority of health concerns the nurse will manage at camp will be minor and easily handled through good nursing care, standing orders, or written health care procedures. Several resources nurses can use in managing common health problems at camp are included in the resource list in Appendix T. Nurses can make a significant contribution to health care quality at camp by encouraging self-care responsibility and continuity of care for members of the camp community.

Promoting Self-Care. Self-care and individual responsibility for personal health can be fostered at camp. When the nurse assumes the role of collaborator, educator, and resource person rather than health care authority or parent figure, both campers and staff begin to assume more responsibility for their own care. For example, a staff member who has an infected toe can be taught what caused the problem, how to soak and dress the toe, and how to recognize signs that the toe is improving or not improving. The nurse can set aside supplies and equipment for the staff member to use and be available for further consultation while the staff member takes responsibility for soaking and dressing the toe twice a day at the health center. As the toe begins to heal, the nurse will help the individual identify health behaviors that will prevent future infections.

The same approach used with staff members can be used with older campers; however, younger campers may need more help with self-care. For example, while a staff member or older camper may be able to manage all aspects of the care of their foot with supervision, a younger camper might be independent in soaking the foot, but need help from the nurse in putting a dressing on the toe. To help younger campers take more responsibility for their care, the nurse might encourage them to decide which times of day to soak the foot and which shoes would be best to wear over the dressing.

Continuity of Care. Regardless of the approach used in a camp to treat health problems, good communication and continuity of care are essential. Some camps have developed systems to improve communication among staff, campers, and the nurse concerning individual health problems. In one method, staff use a form to notify the nurse that a camper is having a problem. A staff member writes a brief description of the problem, duration of the problem, and the camper's name and unit on the form that is placed in the nurse's mailbox or delivered to the health center. This type of communication is useful in nonemergency situations and when counselors cannot accompany campers to the health center. Having the staff member's perspective on the camper health problem can be useful. The form can be adapted so that the nurse fills in a portion of the form

that lets the staff member know the findings or outcome of the nurse's assessment of the problem.

In another system that can be used for referrals to the nurse and follow-up tracking, a clipboard is kept in the camp or unit office. Staff use the clipboard to make notes or write down questions about individual camper health problems. The nurse uses this list to make additional observations or talk with the camper when daily visits are made to each unit. A clipboard or posted list also can be useful to unit staff in keeping track of campers with food allergies, routine medications, or other special health concerns.

A daily checklist of campers that need to visit the health center for routine medications or for follow-up visits is another method that can be very useful in assuring continuity of care. Campers may have difficulty assuming responsibility for such daily visits to the health center. A checklist that they can initial themselves, or one that staff can unobtrusively use to verify health center visits by campers is a useful technique. As with all written tracking and referral systems used in camps, confidentiality of camper health information requires that the checklist be kept in an area to which only unit or other appropriate staff have access.

Continuity of care cannot be assured unless parents also are included in the communications system. Parents should be notified promptly when their child requires an inpatient stay in the health center or receives medical care for a health problem that develops at camp. If ongoing care will be required at home, parents should receive written directions for completing medications or treatments that have begun at camp. Parents need a summary of the nature and cause of the health problem, the treatment received, the phone numbers and addresses of physicians and others who provided the care, the dates of treatment, and the diagnosis assigned to the problem (see sample form in Appendix M). In addition, parents should be encouraged to share this information with their children's regular health care provider in their home community, especially if there is the possibility of reoccurrence (e.g., ear infections) or complications (e.g., strep infections, musculoskeletal disorders).

Physician Referrals

Some health problems in the camp community will require medical care by a physician. Both routine medical care for treatment of illness and injuries, and emergency treatment for serious health problems must be available for all staff and campers when needed. Camps should have a written letter of agreement or contract with a local physician, emergency room, or clinic to see campers and staff who cannot see their own primary care provider. A written agreement with a local hospital also should be obtained so that camp community members can be seen in the emergency room, if needed.

Arrangements with physicians and local hospitals should include information about financial responsibility for all services provided. The agreement usually reflects the system the camp has established for paying health care expenses. This might involve worker's compensation, camp health insurance policies, and/or individual insurance policies. The camp and all local health care providers used should know how services will be billed and paid.

Visits to the camp physician should be scheduled in advance by phone, using guidelines agreed upon by the camp and the physician before the beginning of camp. It may be more convenient for the camp or the physician to schedule several individuals from the camp in a single time period. Some physicians may work with several camps and have a specific time each day set aside to see camp patients.

The nurse may find it helpful to establish written guidelines concerning how visits to the camp physician should be handled. Some of the issues to be considered include:

- Who will accompany campers to the physician visit?
- Must health forms accompany campers and staff?
- Who assumes responsibility for seeing that insurance/billing forms are completed?
- How will information about the visit be conveyed to the nurse, to camper's parents, to the camp director, to the counselor responsible for the camper?
- When and how will prescriptions be filled?

Nurse-Physician Communication. Physician findings and recommendations can be difficult to relay to the nurse when he or she does not accompany campers to physician visits. Other staff may not understand explanations or instructions relating to the camper's problem. When it is not possible for the nurse to accompany campers, some other means for discussing the problem with the physician should be arranged. For example, the physician could complete a form for the nurse or give him or her a phone call.

Occasionally situations may arise in which the nurse will be asked to accept verbal orders from the camp physician or an individual's personal physician. This practice carries with it all the legal implications and risks that exist in hospitals and other health care settings. Verbal orders should not be accepted unless no other alternatives exist; and written orders confirming verbal orders must be obtained as soon as possible.

Inpatient Care and Sending Individuals Home

Occasionally campers become ill enough that they need to be excluded from camp activities and kept in the health center. The decision to remove a camper

from program activities should be based on the welfare of the camper and the potential impact of the camper's health problem on others. Each situation can be evaluated individually, using the following general criteria:

1. Is the illness communicable and could it spread to others in camp?
2. Does the illness or injury make it difficult for the camper to comfortably participate in activities?
3. Does the illness or injury interfere with the staff's ability to adequately care for both the ill/injured camper and the well campers?
4. Does the illness or injury require frequent monitoring by the nurse?

Table 7.1 **Examples of Conditions that May Require Exclusion from Camp Activities or Inpatient Care in the Health Center**

Communicable/potentially communicable illnesses
Childhood diseases: mumps, measles, rubella, rubeola, chicken pox, pertussis
Contagious illnesses requiring treatment
Strep or staph infections — until 24 hours after antibiotic treatment initiated
Bacterial conjunctivitis ("pinkeye") — until 24 hours after antibiotic treatment initiated
Undiagnosed symptoms of infection that pose a risk to others
Diarrhea
Vomiting (2 or more episodes within 24 hours)
Elevated temperature
Oral 101°F or above
Axillary 100°F or above
Tympanic 101°F or above (when set to oral equivalency)
Conditions resulting in pain/discomfort, fatigue, or impaired mobility that affect ability to participate in activities
Ear infections — until antibiotics initiated and pain subsides
Musculoskeletal injuries or other trauma
Conditions/symptoms that require frequent monitoring by the nurse
Head injuries
Continuous day or nighttime coughing
Respiratory wheezing
Difficulty breathing

Table 7.1 gives examples of the types of health problems that could necessitate excluding a child from camp activities or keeping them in the health center.

Day campers with health problems meeting these general criteria usually are sent home where they will be more comfortable. In resident camps, campers may become inpatients in the health center for a day or two until treatment is underway and they begin to feel better. However, if the camp session is less than seven days in length or recovery will take several days, these campers also may prefer to be at home.

Pressure may be placed on the nurse by campers or staff to release someone from the health center before the nurse feels that person is well enough to resume their normal activities or contact with others. Such decisions often involve staff whose absence from their unit creates increased responsibilities for other staff. The nurse must carefully evaluate the ill individual's need for additional rest during recovery and the potential for injury or worsening of the condition if activities are resumed too quickly.

The usual routines and responsibilities of the nurse continue, regardless of the number or acuity of inpatient campers or staff. In addition to the nursing care these patients may require, meals must be brought to them and diversional activities arranged. The nurse may become unusually fatigued when nursing care is required or emergencies occur during the night. Arrangements with the camp director for backup help are particularly important during these times.

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CHAPTER 8

Managing First Aid and Emergencies

Kris Miller Lishner

Despite well organized prevention efforts, sudden, life-threatening injuries and illnesses as well as minor trauma can occur in camps. As a manager and direct care provider, the nurse directs and assists camp staff in setting up the resources, procedures, and guidelines required to respond quickly and effectively to sudden, unforeseen threats to health. This chapter will address management of first aid and response to health emergencies at camp.

Developing a Health Emergency Component for the Camp Health Program

American Camping Association (1993) standards for camp accreditation address preparation for health emergencies by defining the basic requirements for emergency services in camps (see box below). These minimum standards provide a starting point for establishing a comprehensive health emergency component of the camp health program. Camps with high risk activities, long response times for outside emergency services, and campers with specialized health needs will need to expand on these basics to minimize the impact of unforeseen emergencies on the camp community.

American Camping Association (1993) Standards Regarding Emergency Health Problems

E-5	Available on site at all times when campers present: Licensed physician, registered nurse, EMT, paramedic or staff member with current certification in first aid and CPR
E-7	Written policy specifying locations or activities where CPR and first aid certified staff must be present
E-13	Emergency transportation available at all times in camp or through outside community emergency services (per written agreement)
C-6	Pre-trip orientation for campers and staff going on trips concerning how and where to obtain medical and/or emergency assistance on the trip
E-14, BT-7	Written procedures for training camp staff

Effective management of health emergencies, which is part of a comprehensive health program, is based on the camp community assessment and the camp's risk management plan. The response system for health emergencies should be incorporated into the camps's health program and written health care plan, and the nurse and camp administrators should collaborate in carrying out the following steps to set up the emergency response system:

1. Identify potential life-threatening, serious, and less serious health-related incidents that might occur.
2. Identify emergency services available in the geographic area surrounding the camp and set up written agreements with them to provide on-call emergency services when needed.
3. Identify and prepare key staff with equipment, supplies and training to provide first aid and life support in those areas of the camp and program activities where critical incidents might occur.
4. Develop procedures for emergency communication when health emergencies arise and train all staff in the use of emergency communications.
5. Define responsibilities of all staff in supervision of campers during emergency situations.
6. Plan for debriefing and support for campers and staff involved in emergency situations.

Identification of Potential Health Emergencies

Injury monitoring systems suggested in chapter thirteen will provide information about common injuries in camp. Serious and life-threatening illnesses and injuries are much less common in camps. General trends in major causes of sudden morbidity and mortality nationwide are an important source of information. Figure 8.1 contains examples of serious or life threatening events that should be considered by most camps in planning for emergencies.

Figure 8.1 **Categories of Potential Life-Threatening Emergencies**

- Major bleeding
- Respiratory failure/distress
  - Choking
  - Near drowning
- Severe allergic reactions/anaphylaxis
- Poisoning
  - Chemical
  - Animal/insect venom
- Major burns
- Head and spinal cord injuries
- Multiple trauma (usually vehicle or fall related)
- Heat stroke/hypothermia
- Drug overdose/alcohol toxicity
- Complications of existing health problems
  - Seizures
  - Insulin reaction
  - Status asthmaticus

Physical and environmental risks identified in the camp's risk management plan also provide information for planning. For example, horseback riding increases the risk of head injuries from falls and kicks. Also, day camps would consider risks due to vehicle-related incidents resulting from daily transportation of campers by camp or family vehicles. In contrast, resident camps may have less risk of vehicle-related injuries, but greater risk of camper falls from bunkbeds and stumbling in the darkness on the way to the bathroom during the night. Specific types of drowning risks will vary, depending on the type of waterfront or pool arrangements, but all camps with water activities must have specific plans to manage submersion incidents. Emergency response planning evolves from systematic assessment of the locations, activities, and behaviors that might lead to specific types of major injury or illness.

Establishing a Relationship with Outside Emergency Services

Every camp may need outside emergency medical services at some point. At the beginning of the camp season, the nurse should review and update the camp's

list of names, addresses, and phone numbers of local emergency services. The types of services available can vary greatly. Camps in urban and suburban areas often have government supported paramedic and rescue services, or 911 emergency response, while camps in rural and geographically isolated areas often have considerably less sophisticated services available.

In some situations, volunteer fire departments or EMT units may be the only services available. Response time for outside emergency services is critical. A wise strategy is to have employees of the local emergency services drive their emergency vehicle or travel the route to the camp at least once before any emergencies arise so the response time can be estimated. This also allows the emergency service staff to find the camp without the stress of a crisis situation.

Some camps are not accessible by road and may rely on helicopter or water transport for health emergencies. The nurse and the camp administrative staff should designate a landing site and plans for clearing that site of people and vehicles if necessary. Camps accessible only by aircraft or boat need to consider what options they can pursue when weather conditions prohibit the use of these primary rescue vehicles.

The nurse and camp administrators should discuss the willingness and availability of local emergency medical services to respond to situations at a camp with EMS administrators, and, whatever is agreed upon should be confirmed in writing prior to the beginning of camp. Written agreements or letters of confirmation also are needed from emergency rooms, walk in clinics, and other community based medical services that might be used when the camp transports the victim rather than requesting emergency services at the camp site.

Provision of First Aid Equipment and Supplies

First Aid Kits for Use On-Site at Camp. First aid equipment and supplies should be readily accessible in areas of camp where health emergencies are most likely to occur. These sites often include the kitchen, maintenance area, camp vehicles, the waterfront and/or pool, living units, and specialized activity areas such as horseback riding, archery, campcraft, and ropes/obstacle courses.

Materials in first aid kits in camp should be restricted and/or limited to items required to temporarily manage an emergency until more qualified help can be obtained. When a registered nurse or EMT is on site twenty-four hours a day, it is safest to include minimum supplies and equipment in first aid kits that will be kept at various locations within camp. This reduces the risk of individuals with limited first aid background or no training at all misusing or overusing sophisticated emergency equipment.

Usually, the nurse is the individual responsible for setting up and maintaining first aid kits. Kits should be checked and restocked by the nurse on a regular schedule. The types of equipment and supplies made available on the camp site

should be determined by the potential emergency health problems that have been identified. A suggested list is included in the following box. This list will not be appropriate in all situations and should be modified according to the types of program activities offered, the types of campers served, the distance to health services, and the background of camp staff providing emergency care.

Suggested Minimum Contents for First Aid Kits Used in Camp

- Disposable Gloves
- CPR mask
- Skin antiseptic—wipes and/or plastic squeeze bottle
- Absorbent cotton, cotton balls, or clean gauze pads
- Adhesive tape
- Adhesive strip bandages — assorted sizes
- Individually packaged Sterile dressings — 4x4; 2x2
- Conforming gauze rolls 2"
- Scissors
- Small notebook and pencil
- Sealable plastic bags for contaminated materials
- Emergency phone numbers

Additions to kits in specialized areas

- Waterfront: Plastic airways, backboard
- Maintenance area: Instant ice packs
- Other program areas: There may be health care items specific to other programs that should be considered (i.e., ropes course and horseback riding areas have instant ice packs)

Items that should *not* be put in first aid kits deserve some special attention. Aerosol containers of antiseptics, insect repellent, or any other material should not be included. These items can overheat in the sun, and they may accidentally discharge into the eyes or face during an emergency or through inappropriate handling by a camper. Glass containers should not be placed in first aid kits because they may contaminate all kit contents if they break.

For kits that will remain in camp, medications of any type should *not* be included. Medications are the most inappropriately used items in first aid kits. Even medications like acetaminophen or aspirin can be used inappropriately by staff or campers. Having these medications available in kits increases the likelihood they will be used for treatment of symptoms that are not discussed with the nurse. Medications in first aid kits also may be deliberately misused. For example, in one camp, a teenaged kitchen worker had an emotional breakup with her

boyfriend on the phone. She went to the kitchen first aid kit, removed the bottle of aspirin and swallowed the entire contents in a suicide attempt.

Storage of first aid equipment and supplies should provide protection from damage or contamination. Some type of air and waterproof box or container will be necessary in humid climates or at locations where they might be exposed to rain or splashed water. Most supplies should be stored in sealable plastic bags to protect contents from moisture, dirt, splashes of blood, or other body fluids during use of the first aid kit.

First Aid Kits for Out of Camp Trips. When campers and staff leave camp on wilderness day trips or overnight trips, additional supplies may be needed in the first aid kit. The further the trip takes the group from health and emergency services, the more sophisticated the first aid kits and the training of the person responsible for health care on the trip should be. Additional equipment and supplies to consider for groups that will be gone two nights or more, or will be more than one hour from emergency services are included in the box below.

Suggested Additional Contents for Out-of-Camp First Aid Kits

- Plastic airways
- Inflatable splints
- Emergency ice packs
- Needles and tweezers
- Thermometer
- Triangular bandage
- Ace bandages
- Steri-strips
- Insect repellent
- Sunblock
- Moleskin
- Camp and emergency phone numbers
- Coins for a pay phone
- Individual camper medications
- Emergency medications: EpiPens®, pain relievers, antihistamines, electrolyte replacement packets
- Mechanism for purifying water (before use of chemical tablets or household bleach, check with local health department)

With the exception of medications, the same materials that should not be placed in first aid kits and storage containers also should not be put in trip kits. When watercraft are used for trip transportation, waterproof storage containers that will float or can be tied to the boat are necessary.

Training Staff to Respond to Health Emergencies

Designated staff must be certified in first aid and CPR in order to respond to health emergencies and provide life support until professional help arrives. Some camps hire staff who already have first aid and CPR certification; other camps include CPR and first aid certification in their precamp staff training. Generally, nurses will not be conducting staff training for certification. Most nurses are not certified as instructors and utilizing them for this purpose is neither appropriate nor the most efficient use of the nurse's time.

All staff must receive training from the camp in how first aid and CPR skills should be applied in the individual camp setting. This training is in addition to the certification staff may already have and must provide the specific details of the staff member's responsibilities in an emergency situation. Part of this training would include how those specific responsibilities might differ for a waterfront emergency as opposed to an emergency in one of the living units. This type of training is best managed by the nurse, perhaps in collaboration with camp administrators. Information covered should include:

- The communication system to be used *in this camp* when an emergency arises
- The types of emergencies most likely to occur *in this camp*
- The way to obtain help from the nurse or other health professional *in this camp* as quickly as possible
- The location of first aid kits *in this camp*
- The contents of each type of first aid kit *in this camp* (kitchen, waterfront, units, horseback riding, etc.)
- The way to use each item *in this first aid kit* (Demonstration and return demonstration recommended)
- The way to handle blood and body fluids in emergency situations *in this camp*
- The way to handle contaminated materials in an emergency *in this camp*

Additional Skills and Training for Staff Who Lead Trips. Out of camp trip leaders need more emergency and first aid skills than do other staff. They need instruction and practice in using the additional supplies in the trip first aid kit. They also need thorough and complete instructions about any medications they might give on the trip, including emergency medications such as injectable epinephrine.

Trip leaders or other staff also must assume responsibility for non-emergency daily health care for their campers. This may involve administering individual

medications or providing other types of care for existing health problems. The nurse must spend time teaching these staff members about the specific medications and health problems of campers who will be on trips so that these pre-existing conditions do not *become* emergencies during the trip.

Some camps send trips out for extended periods (five to fourteen days or more) into wilderness areas with virtually no access to emergency health services. There are no recognized formal standards for health emergency training for leaders of these trips beyond basic first aid certification. These trips put the camp, trip staff, and the nurse at considerable legal risk should a major health emergency occur when help is not available.

Most nurses do not have the highly specialized background necessary to consult with staff on how to manage emergencies in wilderness areas. Even though there are numerous publications that address wilderness medicine, camps should not rely on these publications as expert information appropriate for their specific situation. Nurses working with camps that sponsor such trips should insist that decisions about appropriate staffing, training, and supplies be made in collaboration with an expert consultant, preferably a physician or clinical nurse specialist, with background in emergency and/or wilderness medicine.

The Emergency Communication System

Communication can be a life and death matter during a health emergency. Each staff member, and campers as well, need to know exactly what they are supposed to do when an emergency arises. Each step in the lines of communication in emergency situations should be clearly written in the staff manual. In addition, emergency phone numbers and the appropriate channels for information and reporting should be placed in each first aid kit, posted in each living unit, and by each phone in camp.

Initial communication should always be directed at getting the most highly skilled health care staff member to the scene of the emergency as quickly as possible. This is one of many reasons it is necessary for the nurse to have a way to let others know where he or she is in at all times. The use of beepers, cordless phones, and other types of mobile communication are increasingly used in camps and can be explored as a way to contact essential staff and outside help in emergencies. Sometimes the nurse accompanies ill or injured individuals to the emergency room or hospital. The communication plan for emergencies should specify who is notified when this occurs and who will be in charge of health care for the rest of the camp if there is only one camp nurse.

The camp director should be contacted immediately whenever a health emergency arises. The director may need to confer with the nurse about calling outside emergency services and the director is the appropriate person to make contact with family members of the camper(s) or staff member(s) involved in the

emergency. The camp director is usually the person designated in the communication plan to handle inquiries from the media or other outside parties who may seek information about an incident.

Staff Training in Use of Emergency Communication System. A written description of the emergency communication system should be part of the camp's written health procedures and included in the staff manual. During staff training, when emergency procedures are discussed, the importance of following the communication system set up for the camp should be stressed.

Precamp staff training is an ideal time to set up a practice drill for emergency procedures so staff have an opportunity to actually go through each step of the communication process, as well as the other emergency procedures. The more realistic these practice sessions are, the better staff will remember them. Many nurses have participated in mock disasters in their home communities. Carrying out this type of simulation using a seriously injured camper or staff member could begin with a staff member finding the victim unconscious and continue through the point where the EMS arrive to transport the victim. When such a drill is conducted during precamp staff training, a debriefing and evaluation session should follow so that any problems in the procedures can be worked out before camp begins.

Emergency Communication on Trips. Groups that leave camp for trips taking them into a wilderness or isolated area for a day or longer must have a plan for securing emergency assistance in the event of a major injury or illness. Trip groups should have telephone numbers of emergency medical services and hospitals *in the local area where the trip will occur*. For travel camps that cover long distances, the trip leaders should have emergency numbers and addresses for each day of the trip.

Groups on wilderness trips should have some means of contacting help immediately in the event of a health emergency. Many camps now provide trip leaders with cellular phones, portable CBs, or sophisticated radio equipment. When this type of communication is not available in isolated areas, usually one of the trip leaders must leave the group to seek help, which can leave the group in a crisis situation with less than adequate leadership.

Whether or not camps should sponsor trips where campers (at least campers who are children) are taken on trips into areas where emergency medical services are more than an hour away is questionable. Some camps do sponsor trips into areas that are not accessible by helicopter or emergency vehicle. For example, some camps send campers on sailing trips in bodies of water where weather conditions can change rapidly. Many camps also send groups on trips with no means of emergency communication, such as mobile radio equipment or CBs.

Nurses who work with camps that sponsor trips into areas where emergency medical assistance is not easily contacted and accessible should consider the

potential consequences carefully. Usually, the risks outweigh the benefits. Camps may try to solve these problems by sending an EMT or highly skilled trip leader with wilderness rescue experience on the trip. This does not eliminate situations that require emergency treatment in a hospital setting, nor does it account for the possibility that the highly trained trip leader will be the individual that requires emergency medical services.

Supervision of Campers During Emergencies

The system set up for responding to emergencies both in camp and on trips should address supervision of all campers during the emergency. Protecting campers not directly involved in the emergency from unsafe situations and traumatic experiences should assume high priority. Often staff members become excited and wish to help during an emergency, sometimes rushing to the emergency location without giving thought to their campers.

The nurse should stress the importance of camper supervision and how a responsible adult can help campers cope during an emergency situation at precamp staff training. When a health emergency occurs, the nurse will be directly involved and may be unable to make sure other campers are being cared for. One measure staff can take is to spend time during precamp training developing several alternative activities to engage campers away from the location of emergency situations. Certain staff should be designated to assume responsibility for setting up and leading these activities when an emergency occurs.

It is critical to supervise campers during emergencies on trips out of camp. With fewer staff available, health emergencies can require the complete attention of all staff members on a trip. A plan for keeping other campers safe and calm should be devised *before* an emergency arises. Camp should decide how many staff members will accompany campers on trips and the background of the staff, keeping potential emergencies in mind. Trips with only two staff members can face a crisis if one of the leaders is injured and the other must go for help, leaving campers with little or no supervision. The nurse can assist in planning for health emergencies and camper supervision on trips by helping trip leaders think of how they would manage various emergency situations before trip groups leave camp.

Debriefing and Support for Individuals Involved in Emergencies

One of the most commonly overlooked aspects of emergency response systems in camps is that of providing an emotional outlet and support for those who witness or experience an emergency. Regardless of the outcome, staff and campers alike are frightened and sometimes confused by emergency situations. Feelings and actions during a crisis are usually intense and sometimes desperate.

Observers and bystanders, as well as victims, sense the intensity of the situation, and can become overwhelmed by their empathy and inability to do anything. Each situation will require slightly different approaches to providing emotional support and help for community members involved. Below is a summary of the characteristics of responses that may provide support for campers and staff following a health emergency at camp:

- Clear explanation, in understandable terms, of what really happened
- Honest answers to questions of why the incident happened—even when there is no good answer
- Opportunities for each camper/staff member to openly express their feelings without comment or critique from others
- Acceptance of the need to discuss and reprocess the event numerous times over several days or weeks (including when campers have returned home)
- Reassurance, especially for children and adolescents, that everything possible is being done to see the incident does not reoccur

Children often respond to serious illness or injuries in others by feeling more vulnerable themselves. They may need reassurance and information about what is being done to protect them from the same emergency. The nurse should be proactive in helping staff respond to children's concerns and provide opportunities for campers to talk and express their feelings. Staff want to be assured that anything that can be changed to prevent similar incidents in the future will be changed. In general, adults are more likely to show their vulnerability by questioning the handling of a situation or expressing their anger by asking why more preventive measures were not in place. In the role of a counselor, the nurse must help staff deal with feelings of vulnerability and anger.

Emergencies cause tension in camp communities. Talking about health emergencies after they occur will help prevent rumors and misinformation from increasing the anxiety. The nurse should be the source of accurate information about the health conditions of persons involved in an emergency. Care must be taken, however, to prevent sharing of confidential health information with individuals who are not entitled to that information. Invasion of personal privacy and violation of the privacy laws are never justified, even when it might allay the concerns of others in camp.

Parents and guardians of campers need accurate information about emergencies their children have witnessed or been involved in. Information should come to them directly from the camp. Parents of campers who are ill or injured should be contacted about consent for treatment and receive information immediately following the incident. Parents of other campers directly involved, but not seriously ill or injured, probably should be contacted by phone following the

incident so they can continue to provide emotional support to their child when they come home or through their letters to the child at camp. A letter from the camp to *all* parents should be sent explaining what has happened so they can give the child support and have a clear and accurate explanation of what happened.

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CHAPTER 9

Management of Medications in the Camp Community

Kris Miller Lishner

Managing medications is a significant part of the camp nurse's job. This task becomes increasingly complex each year. First time camp nurses are often amazed at the number and variety of medications campers and staff bring with them to camp, as well as the number of medications that are inadequately identified or inappropriate for the camper (Lishner and Busch 1993; Rudolf, Alario, Youth, and Riggs 1993). Most camps need to pay considerably more attention to medication monitoring and documentation.

Qualifications for Managing Medications

Mishandling of medications by inadequately prepared or untrained camp staff is one of the areas of highest risk. Camps cannot afford to use less than professional nurses as health care staff when it comes to monitoring medications. In order for the nurse to safely manage camper and staff medications, he or she should have the background for and know the following:

- Potential drug interactions
- Expected effects, and how and when to observe for them

- Negative or unexpected side effects
- Drug information resources: where to find and how to use the resources
- Appropriate labeling and storage
- Correct documentation
- Calculation of safe dosage levels
- Ability to recognize inappropriate use patterns among campers and staff
- Ability to make considerations in changing the schedule of administration of medications
- Ability to educate parents/guardians, campers, and staff about safe use of medications at camp

Administrators of some camps may believe the scope of their health program does not warrant hiring a registered nurse, but camps must guarantee the safety and effectiveness of medication management by hiring a qualified professional with the knowledge and background necessary for this task. A part-time nurse who helps with screening in resident camps or check in on arrival in day camps could provide an initial evaluation of medications brought to camp. This should be followed by occasional on site monitoring and consultation regarding positive and negative effects of various medications, problems that arise with medication administration, and staff education.

Common Types of Medications Administered in Camps

Administration of medications accounts for as much as 40-60 percent of all recorded visits to camp health centers in some camps (Asnes, Feldman, Gersony, Morrison, and Weiss 1974; Lishner 1986, 1988; Rotman and Schmalz 1977). The types of drugs administered at camp include continuing and PRN (as needed) prescriptions brought from home, over-the-counter medications brought from home, medications included in the camps' standing orders from a physician, and medications prescribed for an individual camper or staff member by a local physician serving as the "camp physician."

Studies of medication use patterns in more than 250 camps across the country (Lishner and Busch 1993) indicate the most common categories of drugs administered include: antihistamines and decongestants, analgesics, antibiotics, bronchodilators, cerebral stimulants (e.g., methylphenidate).

Camp medication patterns obviously reflect the types of health problems experienced in the camper population. For example, nurses in most camps should expect

to work with campers who have asthma and may need both continuing and PRN medications to manage acute attacks. Also, the frequency of methylphenidate administration suggests large numbers of campers being treated for hyperactivity and attention deficits. These are the most frequently administered drugs reported by camps. Also reported as given, although not as frequently, are drugs such as antidepressants, anticonvulsants, AZT, growth hormone, allergy desensitization injections, birth control pills, and homeopathic remedies. This wide variation in types, sophistication, and complexity of medications that campers bring to camp supports the need for well qualified staff to supervise their administration and for carefully organized systems for monitoring medications at camp.

Procedures and Practices for Management of Medications

Before Camp Begins

Effective medication management begins well before camp starts. Many of the problems that arise with medications result from poor communication among the camper's family, personal physician, and camp health care staff. Precamp mailings to parents and camp staff should include clear and detailed instructions about how medications are handled by the camp. Essential elements to stress in precamp information are listed in the box below.

Parents can be encouraged to call the camp office when they have questions about sending medications. Some camps have parents and staff complete a separate drug information form for each medication they will be taking. Appendix N offers an example of a medication information form to be completed by a physician, with a section for additional information from a parent. This information is essential for camps that do not have professional nurses or physicians on site. Camp staff who are not health care providers are at very high risk when they administer medications. All staff who give medication to campers must have the information necessary to perform the tasks safely. It must be emphasized that drug information forms *do not eliminate risk* associated with administering medications. However, complete and detailed information *may decrease the likelihood* that errors will be made or camper safety compromised.

Some camps accept responsibility for administering over-the-counter and prescription medications when they are accompanied by a note or directions from parents only, with no validation by the camper's physician. This is a dangerous practice. In allowing this, camps are assuming that parents are knowledgeable and fully aware of the effects of a medication, and this is often not a valid assumption.

Essential Elements to Stress in Pre-Camp Information

- For the safety of everyone in camp, all medications must be stored in the health center
- Over-the-counter medications should not be sent/brought to camp by campers
- Only medications prescribed by a physician will be administered at camp
- If a camper will need to take a medication for which there is no current prescription, your physician should write a prescription or a note to the camp authorizing administration of the medication (this can be done on the physical exam form)
- (For camps with physician's standing orders) A limited number of common over-the-counter medications and prescription medications can be provided to campers and staff under the standing orders provided for the camp by a local physician
- The camp will not give campers any medications that are improperly labeled or not prescribed by a physician
- All medications must be in an original pharmacy container with the correct name, date and instructions on the bottle
- Telephone calls will be made to parents and/or physicians concerning all medications about which there are any questions involving safety

The following examples illustrate the potential for harm based on good intentions. At a resident camp where campers stayed the entire summer, a fourteen-year-old girl arrived with a bottle of vitamin A supplements accompanied by a note from her mother stating the camper should take several pills each day. The camper had read that vitamin A could reduce acne and pimples. The nurse in the camp was immediately alarmed by the high dosage the camper would be taking. Because vitamin A is a fat soluble vitamin and stored in the body, serious toxic effects are possible with high doses over time. The nurse contacted the parents and the family physician to question the safety of the medication. When the nurse and the physician informed the parents about the potential effects of hypervitaminosis, it led to discontinuation of the medication. If the nurse and the camp had accepted responsibility for administering the vitamin A without question or review in this situation, it could have resulted in harm to the camper.

When asked to provide a prescription and complete information about drugs that must be taken at camp, most parents are cooperative and appreciate the camp's concern about their camper's welfare. Research suggests that up to 50% of American children who take medicines at home are not using them properly (National Council on Patient Information and Education 1989). Precamp mail-

ings allow campers, families, and staff to learn about responsible use of prescription and over-the-counter medications. Those parents who question the camp's approach deserve an explanation of the policies and procedures, but nurses should not allow themselves to be put in the position of administering medications for which they have inadequate information or no legal basis (prescription or standing orders) for administration.

Processing Medications at Screening or Arrival Check-In

When medication forms are mailed to families and returned prior to the beginning of camp, the nurse has time to check information and clarify any missing or incomplete data. This provides the nurse with basic information when assessing the camper's knowledge of the medication and planning the best schedule for administering it while at camp.

Some medications may be delivered to the health center by parents, staff, or campers as soon as campers arrive on the first day. More often, they are brought to the health center when campers come for screening (resident camps) or check in (day camps). Because a great deal of information must be processed and observations made and recorded during screening or check in, careful and systematic processing of medications should be incorporated into the screening procedures. When other staff help with screening/check in, the nurse must see and review each medication brought in and any accompanying information. The list below includes points to be considered when checking each medication brought to camp.

Examine each container for:

- Name of camper
- Name of medication
- Dose, and frequency of administration (amoxicillin 250 mg; take 1 tablet twice a day)
- Expiration date
- Name of prescribing physician
- The number/amount of medication is sufficient for the length of the camp session (some resident camps count and record the number of pills at the beginning and end of the session)
- Storage instructions (refrigeration, exposure to light, etc.)

Specialized drug delivery systems (injectable, metered dose inhalers, nebulizers, rotocaps):

- For metered dose inhalers, a second or backup container of medication should be included
- For nebulizers, make sure all equipment and instructions are included
- For injectables, make sure appropriate syringes and needles are supplied

During screening or check in, or immediately afterward, the nurse should talk with each camper who will be taking medications. This time should be used to assess the camper's knowledge about his or her medication, arrange the best schedule for receiving medications, and to get any additional information that may be helpful in safe use of the medication at camp. A summary of basic areas for discussion is included in the box below. This time also should be used to talk with both the camper and the primary counselor any questions they have about how the medication will be managed.

Areas for Discussion with Campers about Their Medications

For continuing medications	What is the camper's basic knowledge of the purpose and effects of the medication?
	What schedule/routine has been in use for the medication at home?
	Any differences between the directions accompanying the medication and how the medication was used at home?
	Has the camper experienced any side effects from the medication recently?
Additional questions regarding PRN medications	When at home, how do they decide they need to take the medicine?
	How often have they usually needed the medication at home?
Information the camper needs	Where and how they will get their medications?
	What to do when they need a PRN medication?

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Problems with Inadequate Information or Inappropriate Medications

Despite the best efforts, many campers arrive at camp with unlabeled and inappropriately packaged medications. Often, even when appropriate information is included, the campers report they have been using a modification or entirely different set of directions at home. The nurse needs to carefully assess and follow up on these difficult situations. Families and physicians should be called for clarification. It is the responsibility of the camp and the nurse to see that medications given under their supervision are safe and appropriately administered. Incorrect or inappropriate directions from a parent do not relieve the nurse or the camp of responsibility for identifying unsafe doses, inappropriate use of a medication, negative side effects, and all the other potential problems that can occur with drugs.

Campers occasionally bring inappropriate medications to camp. Drugs prescribed for other family members, samples from drug companies, and homeopathic remedies are examples of medications whose use should not be encouraged at camp. When families insist on campers receiving these medications, the nurse should require parents to obtain a physician's prescription to keep in the camp records. Medications that cannot be given at camp should be returned to families as soon as possible, or stored in a locked cabinet until the end of the camp session when they are sent home with the camper.

Administering Medications During the Camp Session

Medication Storage

All medications in camp should be stored in a locked cabinet in the health center. Some parents may be concerned that their child's medication will not be in their possession at all times, and staff occasionally consider such a policy an invasion of privacy. However, reducing the risk of inappropriate use or tampering by other campers, staff, or visitors outweighs the potential inconvenience of having medications stored under lock. In addition, research suggests that considerable misuse by campers can occur when administering of medications is not supervised and managed by health care staff (Rudolf, Alario, Youth and Riggs 1993). American Camping Association standards (1993) also support storing all medications in a locked area.

Medications requiring refrigeration also must be kept under lock. Often a camp maintenance staff member can fasten a lock to the outside of a refrigerator. When this is not possible, a locking storage container that will fit inside a refrigerator can be used. When all medications are kept in one room in the health center, that room can be kept locked to accomplish the same purpose.

Controlled Possession

Emergency medications will require some adaptation of medication policies. The most common exceptions for locked storage of medications include metered dose inhalers (MDIs) for individuals with asthma and EpiPens® for individuals with hypersensitivity to bee stings or foods. These medications will be of little use if not immediately available when needed. American Camping Association standards (1993) recommend these drugs remain under the "controlled possession" of the person responsible for administering them. Generally, this would be a staff member responsible for supervising the camper. However, in the case of MDIs, the staff member would not administer the medication but would provide the MDI to the camper for self-administration.

The nurse must make decisions continuously about allowing controlled possession and self-administration of medications by staff and campers. He or she also will have to teach and demonstrate to staff and campers the appropriate procedures for administering these medications, as well as precautions for preventing access to the medications by others. It can be dangerous if someone who does not need a medication uses it inappropriately. However, it can be an even more frightening and potentially lethal experience for the nurse and camper alike if an MDI is empty when needed because other campers discharged all the medication by playing with it. Responsibility for controlled possession of medications should be delegated only to mature staff who have demonstrated the ability to take this duty seriously and learn the information and procedures necessary.

Administering Medications to Individual Campers and Staff

Systems for administering individual doses of medications to campers and staff vary from camp to camp. The two most commonly used approaches are (1) having each person come to the health center to receive each dose of medication at a pre-arranged time, and (2) having the medications delivered to each person by the nurse, often in the dining room at meal times. Both advantages and limitations of these two approaches are summarized in table 9.1.

Table 9.1 **Strengths and Limitations of Two Medication Delivery Systems**

Each individual goes to the health center to take all medications	
Strengths	Campers assume responsibility for obtaining their medications
	Quiet and privacy for assessment, teaching, talking with camper
	Medications secured at all times
	All resources close at hand
	Other treatments can be done at the same visit if needed
Limitations	Camper loses time from activities and socialization
	Emergencies or sick campers being treated may increase waiting time
	Campers who forget to go to the health center for medications must be tracked down
Medications are brought to each individual in the dining room	
Strengths	No time lost from activities
	More medications can be given in a shorter period of time
	May decrease emphasis on medications as a major "event" of the day
Limitations	May interfere with time nurse spends with camper groups at meals
	Noise and confusion of dining room may increase risk of errors, lost medications, omissions
	Lack of privacy when campers take medications in front of groups
	Assessment and observation of effects and side effects very difficult
	Alternative needed for late evening and bedtime medications

Some combination of the two approaches may be possible. Campers needing routine, long term medications could receive them at meals, and campers with short term, acute problems could come to the health center for their medications so the nurse could more closely monitor medication effects. Each nurse must develop his or her medication system based on an assessment of the particular camp, the types of medications commonly given, and the goals and philosophy of health care established for the health program.

Documenting Medication Administration

In many camps medications are not recorded at all or are recorded in the health center log. This approach does not provide information about all medications an individual has received while at camp. A recommended alternative is to record each dose of each medication administered during the camp season on an individual medication form (see Appendix O) and make that part of the permanent camp records that are kept on file for the legal period required.

The individual medication form should include the name of the medication, the amount given, the time, the route, and the initials of the individual giving the medication. When a dose of a medication is skipped or missed for some reason, this should be noted in the individual medication record, along with a brief note explaining the reason for the omission. Medication records also should include information about periodic observations made by the nurse and other staff concerning expected medication effects and unexpected side effects.

Part of staff training about medications should focus on the purpose of the drug and what specific observations to make in looking for medication effects. For example, staff can be taught to note the presence or absence of episodes of wheezing or shortness of breath as indicators of the effectiveness of an asthma medication. The staff member should know to report camper nausea, hyperactivity, or restlessness to the nurse as indications of potential side effects or toxicity due to the same medication.

It requires professional education and experience to assess and document the positive and negative effects of medications on campers and staff. Because staff members usually spend more time with campers than does the nurse, the nurse must confer with staff to obtain the information necessary to make decisions about medications. Staff observations can be invaluable, and they will be more motivated to make observations and share them with the nurse when they feel their information is valued.

Management of Medications on Trips

Camper trips, especially overnight trips, require additional planning to make sure medications are administered without interruption. Generally, the most common practice is to place just enough medication for the doses needed while on the trip in an extra labeled medication bottle that is kept in the first aid kit taken on the trip. Verbal directions for giving the medication, including the time, dose, and any other relevant information, should be given to the trip leader or other staff member who will be giving the medication. In addition, the same directions should be put in writing and placed with the medication in the first aid kit in case any questions arise.

Care should be taken in placing medications in the first aid kit. They should be stored in water tight plastic—not glass—containers. EpiPens® should also be kept in the first aid kit for campers or staff who need them. They, too, should be protected from damage and moisture.

Trip staff often must assume more responsibility than other camp staff for administering medication, including emergency medications. Trip staff who will give medications frequently need more training than other staff in how to administer medications, observe campers for medication effects, and record medications given.

Resources for Learning About Medications

References on medications should be available so the nurse can check dosages, potential side effects, and learn about medications with which he or she may be unfamiliar. A current *Physician's Desk Reference* (Medical Economics 1993), commonly called the *PDR* is necessary. Information about over-the-counter medications can be especially difficult to find. The *Handbook of Nonprescription Drugs* published periodically by the American Pharmaceutical Association (1993) is one of the best references, but it is expensive. A local pharmacist also can be a good resource for the nurse. Some are willing to answer questions about medications by phone, especially if they often fill prescriptions for camper medications ordered by a local physician.

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CHAPTER 10

Health Care Records

Kris Miller Lishner

Despite the slower pace and informal surroundings of camp health care, precise,thorough records must be kept of all aspects of health program operations and all care delivered to campers and staff. The background of professional nurses provides them with the knowledge and skills needed to record camp health care in a manner that meets the standards, requirements, and expectations of outsiders. When camp directors decide which health care staff are appropriate for their health program, they should consider the nurse's understanding of the importance of health records and how to maintain them as an important asset. Less qualified staff, including first aiders and EMTs, seldom have the background and experience necessary to assure quality and thoroughness in camp health record keeping.

The Importance of Camp Health Care Records

Health records provide evidence of the professional judgments and evaluations nurses make in their practice and are essential information sources when questions about health problems at camp arise after the season has ended. Staff and camper records form the basis for communication and continuity of care among families and health care professionals (Iyer and Camp 1991).

In addition to their importance in documenting the delivery of quality care, camp health records are legal documents. According to Iyer and Camp (1991), "The patient's chart has become the determining factor in 80% to 85% of all malpractice lawsuits involving patient care." There is no evidence that lower levels of patient acuity at camp decrease the risk of lawsuits. Records should be

considered legal protection for both the nurse and the camp when they provide evidence of good health care.

Financial reimbursement frequently depends upon health care records. Camper and staff health care may be paid for by either family insurance policies or insurance purchased specifically by the camp for the season. Failure to recover health care expenses because of inadequate documentation can represent a significant financial burden to the camp. Some campers' health care is covered by state Medicaid or other assistance programs that may require very complex reporting and record keeping.

The complexity of health care documentation can be frustrating to both nurses and camp administrators. The need for accuracy and specificity in health record keeping will not decrease. In fact, camps may face *increasing* health care documentation requirements as major changes in our health care system evolve. An organized system for health record keeping that incorporates basic principles of good documentation should be a central part of all camp health programs.

Health Program Records

The types of records needed for camp health program operations and for documentation of care delivered to individuals within the camp community are summarized in table 10.1. Program operations records form a basic outline and summary of how the health program functioned and what happened in the health program over the course of a season. Individual health records provide the details about the health status and health problems experienced by each individual member of the camp community during the camp season. The two types of records are quite different and both are important for effective functioning of the camp health program.

Program Operations Records

With the exception of the health center log, each of the types of program operations records in table 10.1 have been discussed in other sections of this book. They should be considered permanent data maintained and stored for the legal period determined by law in the state where the camp is located. Each form, document, or summary related to operations should be dated with the day, month, and year on which it was completed. Dates and signatures are especially important on the physician's standing orders and have direct bearing on the legality of the nurse's responsibility in carrying them out. Without current signatures and dates, the standing orders are not valid.

Table 10.1 **Types of Health Care Documentation in Camps**

Program Operation Records	
Health plan	Inventories of health equipment and supplies
	Summaries of screening findings
	Injury and illness summaries
	Health program evaluation reports
	Performance appraisals of health staff
	Physician's Standing Orders
	Health center log
Individual Health Records/Information	
Provided to camps by parents, guardians, or individuals	Health history form
	Physical exam form
	Consent to treat form
Collected by camps during the camp session	Patient record of health care at camp
	Medication records
	Incident/injury reports
Collected by camps and shared with outside groups	Worker's compensation forms
	Insurance claim forms
	Social service/agency forms
	Forms for referral to other health care providers
	Letters to parents/other health care providers

The Health Center Log. Maintaining a log of each individual seen in the health center has been a custom in camps for decades. American Camping Association standards (1993) specify that a daily health log should be kept detailing information about the individual, the injury/illness, the treatment, and include the initials of the person who provided care for the individual. The American Camping Association (1993) suggests a bound book with preprinted page numbers for this purpose because courts will accept this form. The format suggested by the American Camping Association can be found in Appendix S.

The traditional health center log is inadequate as a permanent individual health record and should not be used for this purpose (Casey 1993; College of Nurses of Ontario 1991). The log format used in most camps is neither detailed nor thorough enough to comprise a professionally or legally acceptable record of individual health status and health care received. A health center log *is* useful as a daily summary of visits by individuals to the health center and the health problems/issues presented in those visits. In addition to collecting data about illness/injury trends and health center facility use patterns, the log furnishes a chronological record that can help in managing the health center. In some states, this type of record may be required by law.

The health center log should be maintained using general principles of professional documentation and should never be tampered with once completed. Each entry should be initialed by the individual making it. All information that is summarized in a health center log entry should be fully documented in individual health records. Complete, detailed, and carefully written patient care records for all nursing assessments and treatment of individuals should be maintained in one of the several professionally accepted formats now in use for charting in health care settings.

Currently, there is a controversy over who should be responsible for entries made in the log. In camps that employ professional nurses as on-site health care providers, every effort should be made to have all entries made by the nurse. The nurse's entries should be limited to those for visits the nurse has personally managed or supervised. In situations where the nurse is not on-site and health center visits are managed by a first aider or another type of health care provider, guidance should be sought from the camp's legal counsel on how to use a health center log.

Individual Health Records

Three types of information comprise individual camp health records: (1) health information provided to the camp by parents, legal guardians, or the individual staff member/camper; (2) information collected about an individual camper or staff member during the camp session; and (3) information about an individual camper or staff member shared by the camp with other health care providers and/or outside groups. Each kind of information should be managed using applicable legal, ethical, and professional standards for medical records in health care settings.

Information Provided to Camps by Parents, Guardians, or Individuals. In most camps this information includes the health history form, consent to treat form, and (in resident camps) the physical examination form. These forms also are discussed in chapter nine. Camps may receive additional information about campers, such as notes from parents, letters or supplemental data from other

health care providers or social service agencies. Often these focus on special health problems, including allergies, treatments required for chronic illnesses, or details about administering medication. This information becomes part of the "official" health record and should be kept on file with all other permanent individual health information.

It is becoming increasingly important for camps to clearly communicate to parents and staff the value of having this health information before campers and staff arrive at camp. It *must* be available to any health care provider who treats the individual while at camp. Parents often delay in returning health and consent forms until the last minute, or forget to return them altogether. Explaining in precamp mailings that information on health forms can be crucial in life-threatening situations or that delay in treatment can result when forms are not readily available can help motivate parents to return them promptly. Emphasizing the camp's desire to provide the best possible health care for the camper also encourages parents to return forms without delay.

Permission to Treat and Informed Consent. Professional literature emphasizes the need for parental consent for medical treatment of a minor child. English (1990) summarizes many of the aspects of consent for treatment that should be of concern to camps:

- Parental consent to treat is required because children lack the competence to consent to medical care and cannot legally enter into a binding contract
- The need for parental *informed consent* extends to all medical care, although as a matter of practicality it becomes increasingly relevant as the complexity of procedures or treatment increases and the severity of associated risk rises
- Failure to obtain consent to treat a child could result in charges of unauthorized touching (battery), malpractice, or negligence (Rosovsky 1990)
- The need for emergency treatment prior to obtaining consent is a common exception to requirements for parental consent
- Special exceptions in some cases for adolescents, especially those 14 years of age and older, may exist. These can include emancipated minors, pregnant minors, and situations involving contraceptive services, sexually transmitted and contagious diseases, AIDS, and substance abuse

Camp nurses and camp administrators should be knowledgeable about the type of information that constitutes informed consent. The basic elements of informed consent include (Rosoff 1981):

- diagnosis
- nature and purpose of treatment

- probability that the proposed treatment will be successful
- feasible treatment alternatives
- prognosis if the proposed treatment is not given

The issues that arise in camp about parental permission to treat campers most often involve questions concerning when parents should be directly contacted about a health problem their child is experiencing. Nurses frequently treat minor cuts, bruises, and other mild problems continuously at both day and resident camps. Contacting parents to obtain full informed consent for these procedures is not practical. At the opposite extreme, some camps may assume that when the parent signs the standard authorization to treat form suggested by ACA, they need to contact parents only in the event of severe or life-threatening problems. Neither approach is appropriate for most camps.

One reason so many questions arise about consent to treat is that consent is erroneously viewed as a form. *Consent is a process of exchanging information between a patient and their health care provider* (Rosovsky 1990). The exchange of information goes in both directions. Health care providers must have relevant and appropriate information upon which to make recommendations for treatment, and patients must have clear and accurate facts about the purpose and potential outcome of the treatment. With children, parents must be involved in the process of consent. Signing a blanket form allowing the camp to seek emergency or any other treatment does not relieve the camp nor the health care provider of the responsibility to engage in the exchange of information necessary for informed health decision making.

The nurse should work together with the camp director, and camp legal counsel to obtain the most current information on common practices and accepted community standards regarding procedures that require informed consent. Some states maintain lists of such procedures (Rosoff 1981). However, in all decisions about when to contact parents, the guiding principle should be that consent to treatment is a process of communication and not a signature or form. Individuals (and the parents on behalf of children) have a right to be informed and to make the decisions that affect their health status.

Information Collected by Camps During the Camp Session. The amount of health information collected by the nurse about most camp community members is minimal. Often the information from parents and/or outside health care providers simply remains on file with very little added to it because the individual experiences no health problems at camp. However, for individuals who become ill or injured during the camp session, or have pre-existing health problems, complete and detailed documentation must be kept and will be frequently used at camp.

Records of Individual Health Care. A separate, individualized record of all assessments and treatment for each camper or staff member should be kept. Some camps prefer to maintain a file or folder for each person; other camps keep individual folders only for the persons with known health problems and keep health history and exam forms in one master file organized by units or in alphabetical order. Regardless of the system, it should be possible to find quickly all health information about a camper or staff member in one place. This would include the health history, physical exam record (in resident camps), consent form, and relevant information about each health problem experienced and care received during camp.

Examples of types of information and situations that should be recorded for individuals are listed below. Day camps usually have less need than resident camps for comprehensive health records for individuals on file at camp because day campers can be taken for medical care and referrals by parents.

1. Details of all health problems or concerns reported to the nurse or another staff member (including date, time, location, and description of problem)
2. Assessments and observations made by the nurse regarding individual health problems
3. Treatment or management of health problem provided by the nurse, (including referral, education, health counseling, medication including omissions), and all other nursing measures
4. Summaries of reports of health care provided by other staff members on out of camp trips or in camp when nurse was not available
5. Chronologically organized information about observations and nursing care received while an inpatient in the health center
6. Evaluation of effectiveness of care provided, including assessment of responses to medications and treatment
7. Summary of findings and recommendations from referrals to other health care providers
8. Summary of communication with parents/guardians or other staff regarding individual health status

Forms used for recording information about illnesses and injuries vary considerably from camp to camp. However, records kept by nurses should follow one of the professionally accepted formats such as SOAP (problem-oriented charting; subjective data, objective data, assessment, plan), SOAP (IE) (problem-oriented charting; subjective data, objective data, assessment, plan, interventions, evaluation), PIE (problems, interventions, and evaluation), FOCUS (use of foci to identify areas of concern), CBE (charting by exception), or narrative charting (Iyer and Camp 1991; Fischbach 1991). Some of these systems (charting

by exceptions, PIE) require flow sheets and may be more appropriate in camps that serve campers with special health needs requiring more frequent documentation. The American Camping Association (1992) publishes a form called *Camp Health Record: Individual at Camp* (Form FM03) that can be used to chart individual health information. This form provides a section for individual screening findings, but has little additional structure. It is easily adapted to almost any charting system.

Medication Records. Routine prescription medications brought from home that must be taken on a regular daily schedule should be recorded on a medication form developed for that purpose. It is important to have a separate medication sheet for each camper or staff member so that it can be stored with that person's individual health record at the end of the season should questions arise about the medications after camp is over. An example of an individual camper medication record can be found in Appendix O.

With an individual medication record, it is easy to tell at a glance all medications a camper or staff member has received during the entire camp session. Missed routine medications or patterns of frequent PRN medications are readily apparent. In addition, potential drug interactions can be recognized and avoided when there is a single location for documenting medications. Moreover, an individual medication sheet is essential for campers with complex health problems who take numerous medications.

Documenting Care by Other Staff. Staff members other than the nurse sometimes provide first aid or routine health care for a camper. This occurs most often on camper trips outside of camp, or when the nurse is out of camp. Regardless of who provided the care, it must be reported and documented.

Generally, experts recommended that nurses *not* chart care they have not given or directly supervised themselves. One way the nurse might handle these situations is to record them in the individual health record as a secondhand report. When the nurse reports health care in this manner, it should be accompanied by a record of the nurse's assessment and care given when the nurse first saw the ill camper or staff member. The following is an example of a nurse's record of a trip leader's report of an injury on a canoe trip (in narrative format):

> 7-6-94 Returned from canoe trip accompanied by John Jones, Trip Leader. 11:15 A.M. John reports (camper) spilled boiling water on foot during supper on 7/4/94 while camped at Mooselookmeguntic Lake. John reports that an instant ice pack was applied to the burn for 20 minutes, followed by application of a sterile dressing. Incident report form completed by John Jones and his notes about treatment provided attached to this record. Current assessment: 2"x3" reddened, blistered area on lateral right ankle _____ (complete description, including all observations, care provided by nurse, and referral to camp physician)
>
> _____ *Nurse's Signature*

All staff members should be instructed to make a written record of all emergency and other care they provide to campers on trips and bring it to the nurse as soon as possible at the end of the trip. Camps should consider developing a standardized form for reporting health care that goes in the first aid kits on trips. When possible, the original notes made by the person providing the initial care should be attached to the individual health record back at camp.

Incident/injury reports are another form of data collected about campers or staff members. The information that should be included in these records is discussed in chapter thirteen. A copy of the completed form should be kept with the other individual health information forms in the camp's permanent records.

Information Collected by Camps and Shared with Outside Groups

Insurance Companies. Health information may be shared with others outside of camp in some situations, such as worker's compensation and insurance claims. Only relevant and necessary information should be reported on claim forms. Confidentiality of individual health records is extremely important. Staff members may be asked by some physicians or hospitals, where they have been referred by the camp, to sign a form for release of their personal medical information to insurance companies or other health care providers. Parents authorization may be requested by insurance companies in order to get information about medical records to ascertain the validity of a claim. This is usually handled directly between the insurance company and the parent after the claim has been filed by the camp.

Many camps do not provide health insurance for campers or staff during the camp season. Instead, individual insurance or families themselves are expected to pay all health care expenses incurred during camp. As a result, camp nurses increasingly must work with a variety of different insurance forms and billing processes. When camps do provide health insurance, the companies that write policies specifically for campers and staff usually set a very low ceiling for total benefits, often not more than $25 hundred to $5 thousand for any illness or injury. The expectation is that the family's insurance will take over when there is need for hospitalization or extensive treatment.

Insurance forms should be completed with care, and directions provided by the insurer followed precisely. Denial of reimbursement can occur when forms are incorrectly or incompletely filled out. The following list summarizes some of the most commonly made errors in submitting claim forms to insurers who provide camp health insurance*:

- Claim form not signed by a camp representative
- Information about the nature of the injury/illness is not specific
- Policy number is not on the form

- Itemized bills and copies of prescriptions are not submitted with the claim
- Wrong claim form is submitted
- Parts of the claim form are left blank
- Form is completed long after the injury or illness and details are not available
- The claim form is lost or there is a problem with the claim and the camp has not kept a copy of what was submitted
- The person submitting the claim is not knowledgeable about the policy (deductibles, policy limits, etc.)

**Adapted, by permission, from Markel Rhulen Underwriters and Brokers 1993.*

Other Groups. Other outside groups that may require reports or details of health problems of campers include personal physicians or other health care providers, social service agencies, government or regulatory agencies, and parents. Sharing camp health information with governmental agencies could be required for children who are wards of the state or receive Medicaid benefits. Reporting health problems directly to personal physicians may sometimes be appropriate, but usually should be done with the permission of the parents and/or individual involved. Parents should receive an accurate and complete written account of health problems their child experienced at camp.

General Principles of Good Documentation

Internal camp health records, as well as those used to communicate with insurance companies and government agencies should be created using fundamental principles of good documentation. The following box below provides an outline of general principles for use in health record keeping. This list is not all-inclusive and each camp should consult with its legal advisor about specific questions, as well as keep a reference on documentation available for health staff.

Other Issues in Documenting Camp Health Care

Permanent Storage. When the camp season has ended, health records should be permanently stored is an area in or near the main camp office. When questions arise or information is needed, especially from individual health records, they must be readily accessible. Families or health care providers may call requesting information, sometimes requiring timely response. Generally, the most recent records should be the most readily accessible.

Health records must be stored for the period prescribed by law, which usually is five years in original form or microfiche. In the case of minors, this five year

period does not begin until they reach the age of majority (Fischbach 1991). Camps should expect to retain health records almost indefinitely because of this law, and plan for storage space accordingly. These records should be protected from moisture and destruction by insects or animals.

Important Issues in Preparing Health Records (Iyer and Camp 1991; Fischbach 1991)

- Make all records thorough and detailed
- Document only care you provide or supervise
- Leave no blanks on forms
- Sign all entries using first initial, last name, and credentials (J. Doe, RN)
- Use military time to avoid confusion about A.M. and P.M. entries (0845 and 1430 not 8:45 A.M. and 2:30 P.M.)
- Write clearly and legibly
- Be precise, specific, and concise
- Use only approved abbreviations
- Use correct spelling and grammar
- Use only blue or black ink (red and other colors don't photocopy well)
- Put individual's name on each form or sheet
- Include COMPLETE information about each medication (site/route, date, dose, time, and who administered)
- Document as close to observations or care in time as possible
- Correct errors in documentation (late and mistaken entries), using recognized methods (see Iyer and Camp 1991)

Confidentiality of Health Records. Confidentiality of all health records *must be maintained* and is in accordance with federal, state, and local laws and regulations. Parents and staff members provide health information to the nurse and the camp based on the expectation of confidentiality. Although this is true and must be respected, sharing information about camper health status with appropriate staff can increase the quality and effectiveness of the care the camper receives and will be necessary in many instances.

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The nurse should be the primary teacher about confidentiality of camp health records. Staff must be taught that casual conversation about a health problem of a camper or staff member is *never* appropriate. Any health information about individuals in camp can be shared only with persons who have a job-related need to know. For example, a trip leader should be given information about a child with epilepsy, including medications the child is taking, the nature of the seizures the child usually has, and how to manage the seizures while on a trip. It is not necessary that *all* staff in camp know this information, only those who will be directly involved with the camper. In addition, it is not necessary for other campers to know about the child's health problem, unless frequent seizures are expected, or unless the child's parents have authorized release of information to the other campers.

Camp policies about confidentiality of all camper and staff personal records, including health information, should be in written staff policies and discussed with staff before camp begins. American Camping Association standards (1993) also address this issue. All health records and files must be kept in an area that is locked or not accessible to unauthorized staff or other campers. Usually this will be the health center during camp and a locked room or file in the camp office when camp is over.

Release of written health records to outside parties should not be undertaken by the camp without written authorization by the staff member or camper's parents involved. Camps may need to develop a release form to use for this purpose. Exceptions for written authorization for release of health records include investigations of potential abuse or neglect (American Public Health Association and American Academy of Pediatrics 1992) and reportable communicable disease.

Requirements regarding confidentiality are becoming increasingly stringent because of legal action involving disabilities and AIDS. Most camps would be wise to evaluate carefully their procedures for maintaining confidentiality and make revisions as needed. Teaching all staff about the importance of confidentiality is one of the most critical elements in protecting the privacy of all camp community members.

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CHAPTER 11

Health Education in the Camp Community

Kris Miller Lishner

Health education and staff training are frequently mentioned (Casey 1993; Auld and Ehlke 1985; Hamessley 1987) as important tasks for the camp nurse. Despite the importance of the nurse as educator, there is no literature that addresses systematic plans for teaching health at camp. Most camps need more specific information about topics to cover and techniques to use for health education in their health care plans. This chapter introduces the essential components of strong health education in camp health care plans.

Goals of Health Education

Even when camp sessions extend to seven weeks or more, camp is a relatively short experience for most people. Dramatic, long-term changes in health habits and lifestyles are not likely to occur in one camp session. A realistic goal of health education at camp is for members of the camp community to learn the information and skills necessary for self-care and healthy living while at camp. Often this health-related learning will carry over to life at home.

Content Areas for Health Education

What should be included in the health education portion of the camp health program is determined by the needs and goals of the camp community identified

in the health plan. Actual content of health teaching should reflect all levels of prevention — primary, secondary, and tertiary.

Primary prevention education includes both general health promotion and specific protection. Characteristics of the natural environment and the activities offered at camp should be considered when planning health education programs. figure 11.1 presents examples of primary prevention education topics.

Secondary prevention education includes strategies for recognizing and treating health problems as early as possible. Central to this education is teaching counselors and other staff to recognize both general and specific signs of ill health in their campers and refer to these cases to the health care manager. Figure 11.2 provides examples of health education topics that incorporate secondary prevention.

Tertiary prevention topics typically center on ways to keep problems that already exist from getting any worse. Although rehabilitation is an aspect of tertiary prevention, temporary health problems also require prevention efforts. An important aspect of tertiary prevention at camp is helping campers with existing health problems adjust to and cope with new challenges at camp. Figure 11.3 lists some examples of teaching about tertiary prevention.

Figure 11.1 **Examples of Primary Prevention Education for Staff and Campers**

Health Promotion	Specific Protection
Staff	
How to cope with stress	How to prevent sunburn among campers
Communicating effectively with campers	Heading off homesickness
Being a good health role model	Rotten sneakers — the footpath to foot rot
Ways to get campers to rest during rest hour	
Campers	
Who to talk to when you are upset at camp	How to dry your ears after swimming (otitis externa)
Selecting the best food to take on the canoe trip	What poison ivy plants look like

Figure 11.2 **Examples of Secondary Prevention Education for Staff and Campers**

Recognizing and Treating Health Problems Early	
Staff	How to do a tick check
	Recognizing athlete's foot
	Health center policies and procedures
	Early recognition of camper health problems
	How to help with camper screening on opening day
Campers	How to do a tick check
	What athlete's foot looks like
	What to do if you don't feel well — using the health center
	How to get help in an emergency

Figure 11.3 **Examples of Tertiary Prevention Education for Staff and Campers**

Assisting People with Existing Health Problems	
Staff	How to use a bee sting kit
	Recognizing signs of skin breakdown in a child in a wheelchair
	Helping campers communicate with a deaf camper
	Side effects of the medication a camper is taking
Campers	Why you keep taking an antibiotic after your ear doesn't hurt anymore
	What to say to people who make fun of your back brace
	How to keep your poison ivy rash from getting infected

Staff Health Education

Everyone in camp is a health educator and has some responsibility for health teaching. Activity directors, kitchen managers, and administrative staff engage in health education when they point out safe ways to do activities, perform jobs, and maintain environmental health and safety. In their daily routines with campers, counselors are their primary health teachers.

The camp nurse is a health education resource person, collaborator, and consultant for all the staff. The nurse can develop an education plan and teach staff the health information they need to know to do their jobs in a safe and healthy manner. By collaborating and counseling with the nurse, camp staff can choose the best teaching strategies to use with campers or other staff.

Precamp Staff Training

The nurse's duties as a resource person and collaborator for health education, prevention, and health promotion begin with the first contact between the nurse and other staff. Typically this happens during staff training prior to camp. The amount of time available to work with staff during precamp training and the goals or priorities established for the health program have a major influence on what can be taught during this time. Nurses should make the best possible use of precamp training to begin preparing staff for the responsibility of keeping campers safe and healthy. Appendix B contains a list of potential topical areas to be covered in precamp staff training.

Staff health education traditionally has too often been limited to precamp staff training by the camp nurse. However, comprehensive health education should begin with information sent to staff members before camp opens and continue on both a formal and informal basis throughout camp. Besides precamp staff training, discussion of health issues and problems at staff meetings, informal work with staff groups during rest hour, use of handwritten reminders for reinforcement, conversations with each counselor about health problems of individual campers, and nursing rounds in the unit are all situations in which camp nurses teach staff members. De-emphasizing precamp staff training as the *only* time for health education and re-emphasizing health education throughout camp sessions supports the idea that prevention and health promotion are perpetual processes, not static information to be stored in the minds of the staff.

Teaching Strategies that Motivate Staff

Good health teaching is based on the idea that *telling* is not teaching. Merely providing information by talking to people does not ensure that the information

will be understood and used to change health-related behavior. Experts, such as Joos and Hickman (1990), agree that health education is most effective when it is specific, and, as Iverson (1993) argues, when focuses on teaching a skill or concept that addresses an immediate need or problem. For example counselors often have difficulty recognizing early signs of health problems in their campers because the counselors lack experience or motivation. On the one hand, the nurse can use a general approach and tell counselors they should keep a close eye on their camper so they can recognize signs of illness early. This is neither specific nor readily usable information. On the other hand, the nurse can teach them how to do a daily visual inspection of each camper in their unit. This skill-focused approach is more functional.

Teaching that provides functional information to staff might include specific written guidelines on what to look for, times and places the observations could be made, and suggestions about what to do when they see something that concerns them. This type of practical information is easier to learn and is more useful to counselors. Learning becomes even more meaningful if the nurse and the counselor together do a visual screening on the campers in the unit, giving the counselor the opportunity to practice the skill. Another way to give counselors practice applying observational skills is to allow them to assist during the screening process at the beginning of the camp session. Individual counselors can check each camper for athletes foot, skin rashes, or other signs of communicable disease with the nurse directly supervising.

Teaching techniques that elicit active participation of campers or staff make health education powerful and productive. Several methods can be used to get campers and staff actively involved in learning.

Role-playing. Learners apply information by playing the part of a camper or staff member in a fictitious situation. For example, a counselor talks to an eight-year-old who has wet his bed and hidden the wet sheets under his mattress.

Discussion of situations from previous summers. Experienced counselors give examples of applying information from previous situations. For instance, a trip counselor explains a system for having campers apply sunscreen together as a group each day after meals on a canoe trip that eliminated all sunburn on the trip.

Return demonstrations. A staff member demonstrates a skill learned for the nurse/teacher while the nurse provides feedback and guidance. A trip counselor, for example, might demonstrate appropriate use of each item found in the trip first aid kit.

Each-one-teach-one. Each staff member teaches another staff member something new he or she has learned. For instance, each staff member who learns how to use universal precautions in helping a child take care of a minor scrape teaches another staff member how to use universal precautions in the same way.

Case study. A group of staff has a problem-solving discussion using a written description of a situation. In this case, staff members might use a problem-solving approach to a description of a fictitious environmental hazard (exposed roots on a trail) and several injuries caused by the hazard to develop several alternatives to prevent injuries in the future.

Handouts, audio-visual materials, diagrams, charts, and photos can be used with any of these methods to add detail. Handouts that summarize what is learned can be added to the staff manual for future reference.

Health education is not a favorite activity nor a high priority for camp staff members. Motivating them to protect their health and that of their campers is one of the biggest challenges camp nurses face. One effective way for nurses to engage the cooperation of the staff is to make themselves available as resource persons and collaborators in getting a very necessary job done.

Another way for nurses to encourage staff to pay attention to health care issues is to reinforce or reward for prevention and positive health behaviors. This is the most underused means of health teaching in camps. Acknowledging counselors for doing a good job with health promotion is a powerful tool for motivating them. Including health supervision and health promotion activities as specific responsibilities in staff job descriptions and as criteria for counselor recognition and performance evaluations also can help teach the importance of health in the camp community. Examples of such responsibilities that can easily be part of staff job responsibilities include role modeling good personal hygiene, nutrition habits, and rest/sleep patterns for campers on a daily basis; and systematically identifying and trying to reduce environmental (physical and social) hazards in camper living areas.

Camper Health Education

Just as staff health instruction is an ongoing task for nurses, so camper health habits education is a continuous process that begins with arrival at camp. The nurse's first opportunity to talk about good health habits is often at the time of screening. Counselors can begin teaching about health by using informal discussion, role modeling, and demonstrations as they orient their campers to camp routines, activities, and procedures. Timing of health education with individual campers can be less structured than it is with staff, allowing the nurse and counselor to capitalize on teachable moments to make health information applicable to daily life.

Health teaching with campers should focus on adapting health and hygiene routines to camp life. This could include using outdoor toilets, drinking plenty of fluids, hand washing, and universal precautions. Avoiding injuries on hikes,

water safety, fire drills, and what to do when they feel ill are examples of other areas of health teaching staff can carry out at appropriate times in their units, with help from the nurse when needed. Instruction about prevention and management of existing health conditions could include teaching asthmatic children how to store their inhalers safely in their unit, and still have their medication when they need it. The nurse could do informal health teaching with staff as they help campers pack appropriate clothing and sunscreen to prevent sunburn while on a canoe trip.

Developmental Characteristics and Health Teaching

Cognitive and social developmental levels are important in health teaching with campers who are children or adolescents. The following are some aspects of development that are relevant to health teaching.

School Age (7–12 years). In this age group, reasoning ability is limited to concrete objects, actions, and events; children think in terms of what is, not what if. They often refuse to change what they believe, even if given evidence that contradicts these beliefs (Schuster and Ashburn 1992). They cannot fully understand cause-effect relationships (Micik, Yuwiler, and Walker 1987). Nor can they process new or stressful situations fast enough to avoid danger or find new solutions (Schuster and Ashburn 1992). They have inadequate perception of sound, movement, distance, and speed (Micik, Yuwiler and Walker 1987). In addition, according to Micik, Yuwiler, and Walker, (1987), children in this age range attempt daring feats to prove self-worth, and they seek social and peer acceptance. Finally, these children may not be able to recognize symptoms of illness in themselves or others.

Adolescents. Adolescents have an inconsistent ability to think abstractly. Unlike school-age children, they can hypothesize *what if* (Papalia and Olds 1993). Also, according to these experts, adolescence have a sense of invulnerability; nothing will happen to THEM. Also, a preoccupation with body image and privacy limit their willingness to share health concerns with adults, and they have a need to assert their independence from parents and other adult authority figures. Finally, similar to school-age children, adolescents are strongly influenced by peers to take risks.

It is not within the scope of this book to address the developmental characteristics of children younger than school-age. These developmental characteristics affect health teaching as well as other programming, diet, and nearly every other aspect of camp life.

Teaching Strategies

Teaching strategies that the nurse and camp staff use with children differ from those used with adults in some ways. Taking an active part in the learning process is important for children. Also the level of information taught, the way it is introduced and the types of reinforcement for learning must be modified.

Most campers need short, focused educational activities that include concrete situations and examples. They need more help than adults do to understand exactly what to do with the information they receive about health. Active, hands-on experiences help children learn. Adults can be told to dry between their toes after swimming to prevent athletes foot and learn the importance of moisture in fungal growth. School age campers will benefit more from having the nurse or their counselor demonstrate exactly how to dry between their toes and then practicing along with the nurse or counselor. Camper learning will be reinforced every time they see their counselor model this health behavior by drying his or her feet carefully after swimming. Strategies used with children are different from those used with adults, whether they are campers, staff, or parents.

Importance of Role Models

One of the most efficient ways to establish good health habits in children and adolescents is for staff members to model appropriate health behavior. By brushing their teeth, washing their hands before meals, getting eight hours of sleep during the night, wearing clothing suitable for the weather, and following safety rules, staff demonstrate primary prevention and promote health. Campers usually look up to their counselors and other staff, making them ideal health role models. Camp staff members are even more effective role models when they provide simple explanations or rationale for their health habits.

An other effective way to promote health is for tent or cabin counselors to build healthy habits and routines into their campers' daily schedules. When the whole small living group, including the counselor, take showers, wash hands, or rest during rest hour, good health practices become normative behaviors — something everyone does. And just like staff, campers learn to value health when counselors make positive comments or recognize appropriate camper health behavior.

Unlike camp counselors and other staff, camp nurses do a great deal more than role modeling when working with children. For example, demonstrations can be used in teaching appropriate use of inhalers or other medications, applying moleskin to prevent blisters, and teaching similar types of health-related skills. Camp nurses also can reinforce learning with simple written materials or diagrams. This is especially helpful to school-age children who think concretely and benefit by using these types of learning aids.

Developing a Written Health Education Plan

Many camps have developed a list of topics for precamp staff health education training, but have not developed a plan for campers or staff to assist them after camp begins. An organized plan that identifies the timing of topics, and potential teaching strategies for the major aspects of staff and camper education throughout the camp season is a valuable tool for the nurse, especially the novice camp nurse. The plan also is useful because it specifies the responsibility of other staff for health teaching. Appendix B offers a sample subject outline for health education at precamp staff training. Appendix C contains a simple topical plan for campers and staff at a one-week resident camp. Such plans can be developed over several summers, with each nurse adding to or revising the plan.

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CHAPTER 12

Preventing and Controlling Communicable Diseases

Linda Ebner Erceg and Kris Miller Lishner

Communicable diseases pose a significant risk to the camp community because campers and staff live in close proximity, often with fewer sanitation and disease control resources than those that exist in their home communities. Communicable diseases can spread very quickly in a camp. For the sick individual, an avoidable communicable illness can turn summer camp into a bad memory rather than a positive experience. For the camp, time, energy, resources, and good relationships with campers and their families can disappear quickly when communicable illnesses spread through the community.

Types of Communicable Diseases Occurring in Camps

Little research is available concerning patterns of communicable illness in summer camps. Not surprisingly, reports based on camp health log analyses show that sore throats and upper respiratory infections are among the most common reasons for camper and staff health center visits (Asnes et al 1974; Lishner 1986, 1988; Rotman and Schmalz 1977; Schwartz 1980). As in any other community,

human behavior and the environment can interact to produce a wide variety of communicable diseases.

Figure 12.1 **Communicable Diseases Reported in Camps (Erceg 1992)**

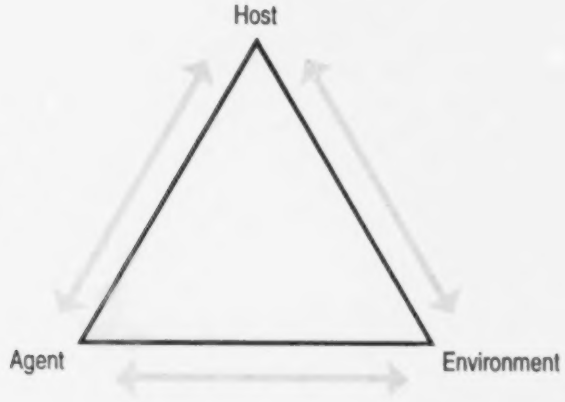
Respiratory	Upper respiratory infections
	Influenza
	Pneumonia
	Strep throat
Dermatologic/Ophthalmic	Scabies
	Pediculosis
	Ringworm
	Viral warts
	Impetigo
	Conjunctivitis
Gastrointestinal	Diarrhea
	Gastroenteritis
	Giardiasis
	Salmonellosis
	Hepatitis A
Bloodborne Pathogens	AIDS
	Hepatitis B
Other	Lyme Disease
	Measles
	Chicken pox
	Mononucleosis
	Encephalitis
	Chlamydia

Accurate summaries from past camp seasons and continuous tracking of illnesses during the current season will reveal the most common communicable illnesses in a particular camp setting. If the community assessment shows that communicable illnesses are not tracked and documented, a system for doing so should be established. Because most communicable illnesses are brought into the camp from the outside, the full range of potential communicable diseases should be considered in prevention efforts.

Factors Contributing to Communicable Disease in Camp

Each part of the classic epidemiologic triangle (agent, host, and environment) and the interactions among them contribute to transmission of communicable disease (see figure 12.2). General health status is one factor that affects immune responses of the individual. Health status is a human factor that can be directly manipulated to reduce the risk of communicable disease. Host or human factors include hereditary resistance and inherent characteristics such as gender and hormonal levels (Stanhope and Lancaster 1992). Nutrition, stress levels, fatigue, and hydration are also examples of individual health factors that can be modified to influence the spread of communicable disease.

Figure 12.2 **Classic Epidemiologic Triangle**



Environmental crowding is another and major factor in transmission of communicable disease at camp. In most camps, dining room seating patterns and serving practices potentiate the risk of sharing contagious illnesses person-to-person. Environmental factors that affect the individual's ability to resist communicable illness include weather and atmospheric conditions such as humidity, temperature, and pollution (including dust and smoke).

Contamination of food and water supplies by *pathogenic*, or disease causing, organisms is the environmental factor that most directly affects the largest number of people in the shortest time. Safety of food and water supplies assumes the highest priority in communicable disease prevention at camp. Governmental regulation of these resources is necessary and helpful but not sufficient by itself to prevent water and foodborne communicable disease.

Agent factors that influence communicable diseases are the characteristics of the specific organism, including virulence, invasiveness, infectivity, and dosage. These elements are more difficult to control in the camp setting than are human and environmental factors.

Because agent, human, and environmental factors in transmission of communicable diseases interact, opportunities exist at many points to intervene. For instance, to prevent the transmission of upper respiratory infections, nurses should focus on human factors such as the sharing of drinking glasses among campers and increasing resistance through adequate rest, nutrition, and fluids. Nurses can also regulate environmental factors to limit spread of the virus. For example, they might exclude sick food-handlers from the kitchen, require careful cleaning procedures in the dining room, and prevent droplet spread of the virus by maintaining maximal distance between heads of beds in the cabin. Nurses have the unique skills and resources necessary to monitor and identify ways to modify factors that contribute to communicable disease.

Primary Prevention of Communicable Disease

Primary and secondary prevention of communicable illness should be a major part of the health program. The camp nurse accomplishes this by using strategies designed to do all of the following:

- Increase the resistance of community members to infectious organisms
- Prevent the release of communicable diseases into the camp community (health screening)
- Monitor for indications of communicable diseases in the community
- Isolate and treat individuals with symptoms of communicable disease

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Intervention With Host/Human Factors

Primary prevention dealing with human factors in communicable disease includes specific protection and health promotion. Immunizations, healthy lifestyles, and personal protective behaviors make up the core of primary prevention.

Immunizations. The most basic level of primary prevention is specific protection against communicable diseases. Basic immunizations for common childhood diseases (mumps, measles, rubella, polio, pertussis, and diphtheria) are the single most effective measures of specific protection in countries throughout the world. Everyone in camp, including staff, campers, and staff family members, should be fully immunized and provide documentation to that effect. Though not a common childhood disease, tetanus is deadly and immunization should be required for campers and staff. In recent years, major changes have occurred in the immunizations recommended by the Centers for Disease Control (CDC), American Academy of Pediatrics, and state health departments. The camp nurse should check with the camp physician and/or the state health department to obtain a copy of current CDC recommendations. Immunization issues that require special consideration and where specific information should be requested from the above sources are summarized in figure 12.3.

In some areas of our country, as few as 42% of some groups of children have appropriate immunization levels when entering school. The United States is ranked embarrassingly low among nations of the world in immunization levels of children (Children's Defense Fund 1993). National health objectives (U.S. Department of Health and Human Services 1990), as well as most groups advocating for children's health, urge greater efforts to achieve better immunization levels. Requiring appropriate immunizations for everyone in camp is one way professional nurses and camping leaders can advocate for better health and health care for all of our children, both at camp and at home.

Camps should make every effort possible to obtain current, accurate documentation of immunization status about campers and staff, even when state law requires completion of immunizations for public school admission. Several factors make it necessary for camps to obtain immunization information: (1) laws regarding immunization prior to school entrance are not consistent from state to state; (2) immunization requirements in other countries are often very dissimilar to those in the United States; (3) enforcement of state immunization laws varies a great deal among local school districts; and (4) state laws and enforcement applied to private schools may be different from those for public schools.

Figure 12.3 **Special Immunization Issues for Consideration**

Diseases	Issues
Measles (rubeola)	Booster immunization now recommended for children previously immunized. Older adolescents and camp staff may need to be re-immunized.
HIB (haemophilus influenzae type B)	Now recommended for children under the age of five. If camp staff with families have young children, they will be exposed through the adult population.
Hepatitis B	Individuals who might be exposed to blood in the job will require immunization or post-exposure evaluation and prophylaxis (see section on blood borne pathogens).
Groups	**Issues**
International staff/campers	Immunization standards vary from country to country. Check with health department/physician when status not equivalent to USA recommendations.
Campers/staff with chronic illness or disability	Conditions affecting immune response (AIDS, cancer, certain medications, etc.) may sometimes delay or prevent immunization. Individuals may need additional protection while at camp and full immunization of all staff and campers is of critical importance. The camp nurse should collaborate with parents and camper's physician in decision-making.
Older adults	Influenza and pneumoccocal risk greater than in younger populations.

Documentation of immunization status should be required on health history forms. The camp needs a policy on how incomplete immunization should be handled. Some camps exclude these individuals until immunizations are obtained; other camps handle the situation differently. The person who is not immunized can be at great risk in some situations. For example, without proper immunization, a pregnant female who is exposed to rubella or a camper who contracts measles and develops encephalitis as a complication could be in grave danger. As the groups served by camps become more diverse, immunization requirements should be considered for each group. Before the season starts, the nurse, the camp physician, and the camp director together should develop a policy that does not needlessly exclude campers and staff from camp, while it protects the health of the community.

Improving Health Status and Resistance. Health promotion is an important aspect of communicable disease prevention. Individuals with poor general health have low resistance to infectious organisms. Good nutrition, adequate fluids, sufficient rest, appropriate activity levels, and limited stress levels are important defenses against communicable disease. The camp nurse can monitor fatigue, stress, nutrition, and fluid intake by observing campers and staff at meals, during activities and normal camp routines. This provides the nurse with information to make recommendations about the pace of the camp program or ways to reduce interpersonal stress. For instance the nurse might suggest bedtime guidelines for cabin units or recommend that an activity be changed to a less physically demanding one when it is hot or humid outside.

Getting campers and staff to eat properly and drink enough fluids is a constant struggle for the nurse, and they are best addressed through her role as collaborator and educator. For example, the nurse and camp staff can plan ways to make water available at activity sites, while assuring that the types of containers and the way they are used do not create a risk of contamination with pathogens.

Health Education. Educating campers and staff is an essential part of primary prevention. Everyone must know what behaviors contribute to the spread of illness and how to avoid those behaviors. Examples of personal behaviors that help prevent spread of communicable disease at camp are included below:

- Wash Hands! Wash Hands! Wash Hands!
- Use universal precautions when in contact with blood or body fluids of others
- Use tissues, turn head when coughing or sneezing
- Don't share food, utensils, other personal items
- Shower or swim daily
- Change clothes daily
- Change bedding at least weekly
- Eat balanced meals
- Drink one full glass of water at each meal, in addition to regular fluids
- Sleep eight hours each night
- Find outlets for stress — exercise, relaxation techniques, mid-day rest

The importance of teaching how and when to wash hands cannot be overstated. Hand washing is the single most important personal preventive measure in avoiding communicable illness. Everyone should be taught how hands should be washed (even when no plumbing is available), when hands should be washed (after toileting, and prior to eating, setting tables, or handling any food), and why the practice is necessary.

Intervention With Environmental Factors

The camp's physical layout, management policies, and geographic location also must be considered in communicable disease control. The objective is to provide a camp environment that does not support disease-causing microbes. The following aspects of the camp environment are especially important in preventing communicable disease: water supply, food service, refuse and sewage disposal, sleeping areas, cleaning procedures, and animals.

Water Supply. The safety of water sources used for drinking and food preparation affects every individual in camp. State or local health regulations in most areas and ACA standards require testing water from camp wells or reservoir systems prior to beginning camp. The nurse may want to review the lab results from water testing because the analysis sometimes includes additional information about iron content (which can affect bowel patterns) and compounds for which some people have developed sensitivity (e.g., nitrates, chlorides).

The water system may be fine at the time of precamp testing but, for a variety of reasons, become contaminated during the camp season. Some disturbances in water quality have minimal impact on community health. Others can be insidious and only noticed when they cause overt health problems. Safety of the water supply should be assessed on a regular basis every two to four weeks and whenever several cases of diarrhea or other gastrointestinal symptoms appear. Because of the number of people that can be involved and the potential seriousness of the consequences, suspected contamination of the water supply should be treated as an emergency. Alternative supplies of drinking water should be made available, and the local health department should be contacted for advice on management of food preparation until the water system is made safe.

Water supply on out-of-camp trips should be obtained from public water supplies or taken with the group from camp. In situations where these approaches are not possible, local water should be decontaminated very carefully and only with expert advice from state health departments or communicable disease experts.

Food Service. Camp food service also can introduce communicable disease into the camp community. The scope and severity of its potential exposure is second only to water supply. The nurse may have only indirect responsibility for health concerns in food service and preparation areas. However, the nurse, food service director, and camp director should work collaboratively to minimize the risk of communicable disease transmission through food service. The nurse should be aware of basic food handling procedures and discuss any problematic practices she observes with either the camp director or the food service director, depending on established lines of communication.

The nurse has direct responsibility for making sure physical examination and health history forms for all kitchen staff are on file. (See Appendix A for a sample Health History and Examination Form.) Kitchen staff with communicable illnesses should be excluded from food handling responsibilities until they are no longer communicable. The nurse will need to address this situation tactfully and with the help of the camp director and the food service director.

Regulations and standards for food service are set by state and local health departments. American Camping Association standards also address some aspects of food storage and preparation. The food service and camp directors must comply with these requirements. Kitchen staff need to be taught about foodborne pathogens and procedures necessary to reduce these risks (Educational Foundation of the National Restaurant Association 1985). This instruction is usually the responsibility of the food service director, unless the nurse is specifically asked to participate. In some camps, lax procedures are more likely to occur when the food service supervisor has a day off or when campers and staff are cooking out in their units. All staff and campers who cook or serve food to others need to be taught how to handle food safely. Trip staff are often inadvertently omitted from this training process. The nurse may need to take responsibility for this group, or for making sure supervision of their food handling education and practices is assumed by a qualified individual.

Besides regulations for the kitchen, sanitation policies are needed also for the dining room. Campers and counseling staff often have responsibility for setting and transporting food to tables and serving the food. Handwashing should be required before they handle tableware or food trays. Tables should be wiped with a sanitizing solution immediately before tables are set and dishes should not be set out until just before meals are served. A scoop should be provided and used at the ice machine.

Staff and camper behavior during meals can be an environmental source of risk to everyone at the table. Staff members need to be taught and encouraged to model appropriate food handing behavior for their campers and to explain why they use the techniques they do. Examples of appropriate food handling measures include:

- Washing hands just before eating
- Using serving utensils rather than hands, or personal spoon or fork for taking food from serving dishes
- Holding on to serving dishes and platers from the bottom or sides, without putting fingers on surfaces containing food
- Coughing or sneezing into shoulder rather than hand or toward the next table

Refuse. Food waste is a primary breeding ground for pathogenic organisms, especially in warm or wet weather. Refuse also attracts flies and other disease spreading vermin. Use of covered containers for food waste is essential. Providing holding areas that are distant from living areas, food storage, and food preparation areas, and removing refuse frequently reduces risk of disease transmission.

Careful management of refuse in other parts of camp is also very important. Waste containers in all parts of camp should be emptied daily. Covered waste containers are needed in women's bathrooms for disposal of menstrual supplies. The camp nurse must make sure that infectious waste is kept separate from the camp community, and he or she must comply with local regulations (Erceg 1993) regarding its disposal.

Sewage Disposal. The camp nurse is not directly responsible for safe operation of the camp sewage disposal system. The system is usually assessed only when a problem occurs or when people begin to smell and/or see contamination; however, the nurse does need to learn about the sewage system and consider its potential impact on disease transmission.

Sleeping Areas. It is difficult to limit the spread of communicable disease in camper and staff living areas. State and local health departments, as well as standards of the American Camping Association (1993) provide guidance in this area. Sleeping quarters should be relatively free from insects and animals. In some areas of the country, this requires that door and window screens be intact and that no animals are kept in the area. Outside doors should have self-closing mechanisms. The nurse may need to help staff and campers find alternative accommodations for campers' toad and/or cricket collections.

Beds and the heads of people in sleeping areas should be kept at a safe distance because many communicable diseases spread through droplet transmission (e.g., common cold, flu, chicken pox). Beds should be arranged to maintain the greatest distance between heads. Most sources, including the ACA standards, recommend a minimum of thirty inches between beds. Since many resident camps use bunk beds, nurses should recommend placing campers so the head on the top bunk is at the opposite end of the head on the bottom bunk. Distances between campers should be considered also in day camps that have a rest period during the day.

Tripping programs present special problems because people are in very close proximity inside of tents. The nurse should work with program leaders in these situations to develop strategies that minimize disease potential while they maintain program character.

Cleaning Procedures. Surfaces and areas that harbor pathogens (bathroom sinks, toilets, counter tops, food preparations areas, coolers, canteens, trip kitchens, etc.) should be cleaned and sanitized frequently. Some programs change camper groups regularly, so beds should be sanitized between groups. Camps that do not have mattresses and pillows with cleanable surfaces should purchase this type as replacement becomes necessary, or they should consider separate plastic covers.

A host of commercial products is available for disinfecting or sanitizing inanimate surfaces in camp. These products are registered with the U.S. Environmental Protection Agency as *disinfectants*. The alternative to these products

recommended by the American Public Health Association and the American Academy of Pediatrics (1992) is a solution of one fourth cup household liquid bleach added to one gallon of tap water. To be effective, the following procedures must be followed (American Public Health Association and American Academy of Pediatrics 1992):

1. New solution should be prepared fresh each day.
2. Surfaces to be disinfected should first be cleaned of organic material.
3. Surfaces should be left moderately or glistening wet with bleach solution and allowed to air dry.
4. A slight chlorine odor should emanate from the solution.
5. If there is no chlorine smell, a new solution should be mixed, despite how recently the solution was prepared.
6. This solution should not be mixed with other fluids, especially acids, because this combination can produce poisonous chlorine gas.

This sanitizing solution also can be used for infection control in the health center by wiping surfaces daily as well as after each exposure incident.

Animals and Insects. Pets and the various wild critters endemic to the camp's location can potentially spread communicable disease. Rabies is associated with raccoons, skunks, and other small mammals. Most staff are aware that some ticks transmit Rocky Mountain Spotted Fever and Lyme disease, but they may be less aware that turtles and birds can harbor salmonella.

The human body is a natural host for several problematic insects. Scabies, pediculosis, and other mites can spread rapidly through camp. Primary prevention is best achieved by decreasing environmental crowding and sharing of personal items. The nurse should contact the state department of health prior to opening camp for an update on the level of animal and insect-related risk at the time. The nurse also should instruct campers and staff about what actions they can take to minimize their exposure (e.g., apply insect repellent for ticks and mosquitoes).

Intervention With Agent/Organism Factors

Mechanisms for altering the characteristics of an individual organism are limited in camp. However, development of organisms that are resistant to antibiotics or especially virulent can be reduced by appropriately identifying and treating communicable diseases.

Secondary Prevention of Communicable Disease

Secondary prevention of communicable disease involves early recognition and prompt treatment of disease in infected individuals. Screening for specific problems on arrival at camp and during camp sessions is a basic mechanism for identifying communicable illness.

Screening on Arrival

ACA standards recommend screening each person within twenty-four hours of camp arrival (American Camping Association 1993). Detecting signs of communicable illness is one of the primary purposes for this process. The sooner people are screened, the better. Waiting up to twenty-four hours to complete screening can be risky because it allows time for someone with a communicable disease to interact with the rest of the community. Indication of exposure to communicable disease sometimes can be obtained by asking the person if he or she has been exposed to someone known to have chicken pox, flu, the common cold, sore throat or other communicable disease within the preceding three weeks. Unfortunately, campers are not always reliable in their reports of exposure, and health histories may not be accurate or up to date. (See Appendix I for a sample health recording form.)

A brief physical assessment for signs of communicable and other types of illness should be completed on each individual arriving at camp. This should include *all* campers and *all* staff. Heads should be checked for lice; skin should be examined for unexplained rashes; body temperature should be taken if there is reason to suspect illness; and the presence of cough, nasal drainage or congestion, and facial flushing or excessive paleness assessed.

For most health problems identified during screening, the nurse should note indicators of concern and recall the individual for a more thorough check later. However, if there is evidence of a communicable illness, the individual should be excluded from group and community activities until the nature of the illness can be determined. Concern for the health of the camp community must take precedence over the untreated individual's participation in camp activities. The decision to exclude campers or staff with communicable disease should be based on the nurse's consultation with the camp director. The ill individual might need referral to the local medical community before moving fully into camp life.

Other Types of Screening

In addition to an arrival screening, there are other types of screening that are helpful in early identification of communicable disease. Some state regulations require tuberculosis (TB) or other testing of staff. This form of screening may be perceived by camp administrators as an inconvenience, but nurses should support its importance and use staff resistance as an opportunity to educate them about communicable disease. There has been an increase in reported cases of TB in recent years. Camps should check with local health departments about availability and advisability of testing for all camp staff, including volunteers.

Finally, screening campers and staff before they leave on out-of-camp trips helps limit communicable disease. Conditions on trips often place campers and staff in close sleeping quarters and require shared food preparation responsibilities. Rapid transmission of communicable disease in isolated areas where health care facilities are not readily available is especially dangerous.

Using a Tracking System

It is essential that a system for surveillance or monitoring illness patterns be in place as part of communicable disease prevention. If the number of individuals with similar symptoms is tracked on a daily and weekly basis, problem areas will quickly emerge. Some camps use the rule of thumb that five people reporting similar health problems within the same four to six hours constitutes an *epidemic* and triggers an epidemiologic investigation. The investigation should not be delayed and can be supported by the local health department. A phone call to consult with the epidemiologist helps determine the scope and method of response without causing unnecessary panic. The consultation also helps the camp nurse keep the situation in perspective.

Isolating Individuals With Communicable Diseases

It is often necessary to isolate individuals with certain suspected or confirmed communicable diseases. An isolation room that can be used when needed should be designated in the camp health center or other appropriate place. The isolation area should have controlled access and a bathroom and be monitored continuously by a trained staff member when in use. It is important to identify campers and staff who have had contact with the affected individual so these individuals can be monitored during the incubation period for the illness.

Deciding which illnesses to isolate can be difficult. Campers and staff with illnesses such as chicken pox or measles are usually more comfortable recovering at home when the travel involved is not excessive and does not expose other people. If these individuals stay at camp, they must be isolated because both diseases can cause serious complications. The risk to the camp community in these cases requires isolation. It is seldom realistic to isolate individuals with colds or mild upper respiratory infections because these illnesses are typically not serious and extremely difficult to prevent entirely. Decisions about the need to isolate and appropriate types of isolation can be made much easier for the camp director and the nurse if they consult with the camp physician and/or local health officials.

Reporting Communicable Disease to Health Authorities

Certain communicable diseases must be reported to local health officials; it is mandated by state law. The camp nurse should ask the local health department for a list of diseases that must be reported in the state where the camp is located. Typical reportable diseases include Lyme disease, measles, mumps, rheumatic fever, salmonellosis, tuberculosis, gonorrhea, and pertussis. Usually, the physician who diagnoses the illness makes the report through his or her office.

Prevention of Bloodborne Pathogens Transmission

The use of universal blood and body fluid precautions is required in camps, just as in health care facilities, schools, and other settings. Hepatitis B presents the greatest risk in terms of total numbers of affected individuals. However, HIV infection is a significant risk among campers and camp staff age groups. Data regarding the prevalence of AIDS cases indicate 20% are reported in individuals between the ages of 20 and 29 (Centers for Disease Control 1989). With a latency or incubation period of 8–10 years (American School Health Association 1988; Bechtel and Sutter, 1990), it is clear many of these individuals were infected as teenagers. The number of HIV infections among 13–19 year olds increased by 40% in 1989 alone (Centers for Disease Control 1990). Public health officials are especially concerned about risks to both adolescent campers and staff in many camps.

Recommendations from CDC (1987) regarding universal precautions in health care settings and guidelines from the Occupational Safety and Health Administration (OSHA) should be used in developing the plan for preventing transmission of bloodborne pathogens in camps. At the time of this writing, application of OSHA regulations in camp settings had not been clearly addressed

by federal OSHA officials. It is highly recommended that state OSHA officials be contacted for specific guidance because regulations will be implemented at the state level (Schirick and Evans 1993). A copy of the bloodborne pathogens standard and all compliance information should be requested. In most states, the OSHA office maintains a consultation division that answers questions and reviews developed plans. Other sources of information that can be useful in developing the control plan for bloodborne pathogens include Brannon (1993), Camp Fire (1993), Erceg (1993), and Dykstra (1990). Key elements of the camp's plan should include the following:

1. **Written Exposure Control Plan**. A written document that includes, at a minimum, the following elements: (a) identification of job classes or tasks with occupational exposure to blood and other potentially infectious materials; (b) procedures for evaluating the circumstances surrounding an exposure incident; and (c) the schedule and method for implementing the various parts of the plan.

2. **Information and Training**. Information should be provided to staff on bloodborne pathogens and their transmission, and training should be provided in prevention measures, work practices, and use of personal protective equipment.

3. **Hepatitis B Vaccination**. All staff who may be exposed and who have not previously been immunized, must be offered the Hepatitis B vaccination series at the camp's expense.

4. **Universal Precautions**. Staff should function under the assumption that all human blood and most body fluids are infectious and the following precautions should be in effect:

   a. Use of personal protective equipment (PPE) when participating in situations that pose risk of exposure to body fluids. In addition to health staff, this requires that gloves be in all first aid kits and CPR shields be available. Further definition of PPE should be based on the level of care needed for the camp's clientele. This may require use of masks, eye shields, and/or gowns.

   b. Housekeeping/cleaning. Methods of cleaning emesis, urine, and other body fluid spills must include decontamination of working surfaces and equipment with an appropriate disinfectant. Potential sources of infectious waste should be handled in approved ways. Areas to consider include disposal of used tissues and bandages in garbage containers, and placing sharps (e.g., syringes, lancets) in approved containers.

5. **Post-Exposure Evaluation and Follow-Up.** Procedures to follow should an employee be exposed to bloodborne pathogens should exist. Confidential medical evaluation, testing, counseling, and post-exposure immunization (within twenty-four hours of exposure) should be provided.

Additional information on OSHA regulations and how they affect camps is located in Appendix J.

One useful technique for limiting exposure to bloodborne pathogens is to designate a limited number of individuals responsible for providing health care and the specific boundaries of that care. Many camps educate staff about CPR and first aid but neglect to describe the limits of providing routine health care. A cabin counselor has different health care responsibilities from those of camp nurse. Trip staff have certain responsibilities when they are on-the-trail and others when they are in base camp. The camp must design the most effective system for their situation, educate staff about their roles in that system, and monitor compliance.

Prevention of Sexually Transmitted Diseases

Adolescent campers and staff members constitute the groups in America at greatest risk for sexually transmitted diseases (STD). With AIDS and hepatitis B now among sexually transmitted diseases, the risks associated with sexual activity have escalated significantly. Historically, the issue of sexuality and sexually transmitted diseases in camp populations has not received much open discussion among camping professionals.

Camp nurses can and must address the issue of prevention of sexually transmitted diseases with camp staff and administrators. With lives at stake, camper and staff sexuality must be discussed. Interventions can vary from camp to camp, ranging from advocating abstinence to providing condoms on request for sexually active staff. In the context of the camp as a community, attitudes about sexuality and sexual behavior reflect the values of the community. It is essential that the nurse, camp administrators, and appropriate representatives of the agency sponsoring the camp together make decisions about approaches to prevent STDs in the individual camp. It also is critical that the probability of sexual activity at camp, at least by some staff, be acknowledged and preventive measures for STDs be put in place. These measures must be consistent with the philosophy, values, and goals of the camp and its sponsoring organization. Even using an approach with which the nurse does not personally agree is better than not addressing this potentially life threatening problem at all.

Figure 12.4 **Summary of Priorities for Preventing Communicable Disease**

1. **Insist on effective and timely hand washing.**
2. **Institute universal precautions for preventing transmission of bloodborne pathogens.**
3. **Screen everyone for signs of communicable disease *as soon as they arrive in camp*.**
4. **Educate continuously about personal hygiene and basic health practices (rest, hydration, nutrition, stress management).**
5. **Monitor the environment constantly for sources of communicable disease.**
6. **Develop a system for early detection of communicable disease by tracking symptoms and patterns of illness among community members.**
7. **Isolate individuals with potentially serious communicable diseases until treatment is obtained.**

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CHAPTER 13

Injury Prevention and Control

Kris Miller Lishner and Mark A. Lishner

Both camp nurses and camp administrators fear serious or fatal injury to a camper or staff member. Very little systematic data have been collected about injuries in camps, although what information does exist (Lisella and Johnson 1980; Lishner 1988; Lishner 1986; Schwartz 1980) suggests that the most frequent types of injuries are either minor to severe, — cuts, wounds, contusions, abrasions; strains, sprains; insect bites; poison ivy; burns; and fractures — or potentially fatal — drowning and vehicle-related. It is important and encouraging to point out that fatal injuries are not common.

Despite a lack of concrete information about camp injury patterns, camp administrators have intensified their efforts to manage the factors that can result in injury to campers and staff. This chapter will introduce some of the more recent injury control techniques and suggest ways in which professional nurses and camp staff can incorporate them into the camp health program.

Injury Control and Risk Management

Injury control and *risk management* both are terms that cause a great deal of misunderstanding. Some health care professionals and camp administrators may not be aware that injury experts have replaced the term "accident prevention" with "injury control." The new term focuses the public's attention on injuries as

being predictable and preventable rather than chance occurrences beyond human control as implied by the term "accident."

Injury is intentional or unintentional damage to the human body resulting from trauma. Injury control programs focus on preventing injury *and* reducing the severity of injuries that occur through intervention in the multiple environmental and human factors that contribute to injury. Requiring life jackets in canoes is an example of an injury control measure to prevent injury (drowning); requiring CPR certification for trip leaders is an example of injury control measures to reduce the severity of injury (drowning). Injury control is part of risk management.

"Risk management" is another term used by camp administrators that causes confusion. Health care providers often incorrectly assume that risk management is another word for injury control or prevention. Risk management is an integrated approach to dealing with the uncertainty of loss. It includes business and financial losses as well as health concerns. Legal, financial, and insurance counsel, camp boards, and other professionals all might be involved in the camp's risk management program. Maintaining liability insurance to prevent financial loss to a camp as a result of legal action is an example of risk management (American Camping Association 1993).

Injury control and risk management both are concerns of everyone in camp. However, professional nurses have the special skills and expertise needed to manage injuries. This enables them to provide leadership in developing comprehensive injury control programs.

Injury Outcomes

Injuries are the leading cause of death for all Americans between the ages of one and forty-four years. It has been estimated that 3.4 million years of potential human life are lost prematurely each year due to injury in this country. This is more than the number of years lost due to cancer and heart disease combined (Centers for Disease Control 1987).

Preventing and reducing the severity of life-threatening injuries should be a major focus of injury control programs at camp. For example, requiring riders to wear helmets during horseback riding should reduce the severity of head injuries due the falls. It must be emphasized, however, that all minor injuries can potentially become major injuries. This is illustrated in what is called the "Outcome Pyramid" (Figure 13.1), which shows the relationship between the frequency of minor injuries and the frequency of serious injuries resulting in hospitalization or death (National Committee for Injury Prevention and Control 1989). When the overall frequency of injuries is reduced and controlled, the severity of injuries also will be reduced. For example, if the number of horseback

trips on a particularly difficult trail is reduced, the number of both minor and severe injuries should be reduced.

Figure 13.1 **Injury Outcome Pyramid**

Number of Injuries Resulting in Death
Number of Injuries Resulting Hospitalization
Number of Injuries Treated in ER, Physician's Office, etc.
Number of Injuries Treated at Home or Not Treated

Most injuries at camp are at the base of the pyramid. These injuries cause little concern because they require limited treatment and result in minimal financial loss. With different circumstances, however, minor incidents could result in death or disability. For instance, falling on a trail could cause a minor bump on a camper's head if his head hits wood chips when he lands. By contrast, another camper might have the same fall result in a subdural hematoma if that camper hits her head on a rock. In short, preventing minor injuries is an important step in preventing life-threatening injuries. Nurses and staff also should do all they can to prevent minor injuries because they can interfere with a camper's enjoyment of camp or prohibit staff from fulfilling their work responsibilities. Even small lacerations, bruises, sunburns, or blisters can make life miserable for campers and staff.

Systematic Injury Prevention and Control

In recent years, the financial and social costs of injury have taken their toll on Americans. Because of these heavy burdens, both the public and private sectors of the country have been focusing on ways to reduce these costs and save lives. As a result, health care providers and other scientists have developed much more sophisticated techniques for injury control than those available even a decade ago. The most important change that has taken place in injury management has been the use of an epidemiological approach similar to that used with communicable disease. Viewing injury as a result of an interaction among the victim, the hazard, and the environment has led to more successful and effective intervention strategies — no more just "teaching people to be more careful."

Newer injury control programs are based on the premise that injuries are not accidents (see box below). Shifting the focus from the victims shortcomings to analysis of the multiple and interrelated human, hazard, and environmental factors that contribute to injury results in more effective ways to prevent them. In some situations, no matter how careful the individual may be, the injury hazard is beyond their personal control: the camp van struck by a drunk driver in another car; the swimmer cut by unseen glass on the bottom of the lake. Potential hazards and the environments in which they occur can be identified and modified as part of comprehensive injury prevention strategies. For example, some roads in camp can be closed or re-routed to reduce vehicle traffic in areas campers use frequently. Holes in fields used for sports can be filled. Dead tree limbs that overhang tents can be removed. Alternative activities can be arranged so as to encourage a social environment among staff that discourages drinking during time off.

Injuries Are Not Accidents

Accidents	Injuries
Definition	
Random, uncontrollable events Cannot be foreseen or prevented "Accidents will happen"	Predictable health problems, controllable, definable
Causes	
Shortcomings of victim Inattention Not being careful Poor supervision	Agent of injury is transfer of energy resulting from an interaction of human, hazard, and environmental factors
Focus for Prevention	
Increasing personal "safety" factors	Analysis of contributing factors
Changing individual behavior	Strategies to counteract contributing factors in the person, hazard, or environment

Camp nurses need to work cooperatively with staff to develop an injury control program consistent with the health care needs and goals identified in the camp community health assessment process. Managing injuries successfully will be a gradual process in most camps. Like any other system, it takes time and effort to create an injury control program. The steps involved in systematic injury prevention and control are: (1) collect information about injury patterns in your camp; (2) analyze human, hazard, and environmental factors that contribute to specific injuries in your camp; (3) develop strategies and countermeasures; (4) implement a plan of action; and (5) evaluate the results.

Injury Control Step One: Collect Information About Injury Patterns

The most useful information to have in order to prevent injuries is an analysis of the specific types of injuries that occur in a particular camp. Individual camps often have a great deal of information about their own injury patterns. Unfortunately, most camps only compile this information for serious injuries and do not effectively use it to prevent future injuries. Collection of data about minor and moderate injuries (the base of the injury pyramid) can strengthen injury control programs.

Old Records

Health center logs, insurance reports, and injury/incident reports from previous summers provide injury data. Insurance and incident reports usually are limited to information about moderate to severe injuries, whereas health center logs should include injuries at all levels of severity. Unless some type of tracking or summary system has been established, reviewing old records can be time consuming. When completed, however, this summary is a very important data source.

New and Ongoing Injury Data Sources

If it does not already exist, a system for summarizing injury information should be established and maintained each summer. At *minimum*, a simple weekly or session tally of the types of injuries occurring should be kept in every camp. A sample form that can be expanded or modified for this purpose can be found in Appendix D. Tracking injuries by age groups, living units, or activities is helpful. A yearly summary of data about injury patterns during the camp season can be developed from the session summaries. Conditions at camp can vary greatly from session to session and year to year. Evaluating whether injury prevention efforts are actually reducing injuries is more meaningful when information is available over several years.

Another useful tool for learning about injury patterns is a modified injury report form for minor injuries. This form is different from the permanent injury/incident report for moderate and severe injuries seen by a physician or emergency room. The latter is required by ACA standards (1993) and most insurance companies (see Appendix E). A brief, modified injury form that asks what, where, and how an injury occurred is very helpful in analyzing factors that contribute to injuries. These forms do not need to become permanent records, nor do they need to be completed indefinitely. However, collecting this data over even one summer can provide a great deal of information about common mild injuries that can be used to prevent them in the future. A list of the types of information to include whenever information about an injury is recorded is provided in Appendix F.

The injury "numbers" obtained from summaries of camp records may not reveal all of the important factors that contribute to injuries or potential injuries. For further information about injuries, the nurse can interview staff and make personal observations of the staff, campers, potential hazards, and the surroundings. Returning staff often can describe specific injury risks they have identified over several seasons or changes in campers and programs that might contribute to injury potential. New staff, coming from a different perspective, may be aware of risks that returning staff might miss. In addition to staff interviews, the nurse's personal observations of the camp site and daily camp life can reveal injury risks. Nurses are especially sensitive to potential hazards because they have knowledge

of human development, anatomy and physiology, reactions to stress, and direct experience with the consequences of injury. Personal observations by staff and by the camp nurse often reveal information about the camp social, cultural, and physical environment not apparent in written injury reports.

Some camps have experimented with videotaping activity or program areas (i.e., horseback riding) where they are concerned about the potential for injury. This provides an opportunity for the nurse, together with groups of staff and administrators, to analyze specific human, environmental, and hazard factors that might result in injury.

Resources are available to help calculate injury rates in a camp and to set up sophisticated systems for injury surveillance (Erceg 1993; Robertson 1992). Such systems are useful in larger camps (200 or more campers and staff) that do not have major fluctuations in enrollment from week to week. Accurate injury surveillance also requires someone on staff with the educational background to develop controls, including criteria and consistency, in the reporting and recording of injury data that will allow statistical analysis and appropriate interpretation of the information obtained. Less complex approaches to monitoring injury patterns can be equally effective in smaller camps or camps with limited resources. There are tools to help camps systematically analyze factors that contribute to various types of injuries in a camp. These are described in the next section.

Injury Control Step Two: Analyze Factors That Contribute to Injury

Even more important than the type of monitoring system in place is the way in which information about injury patterns is used. Injury management programs should give at least as much attention to preventing injuries as they do to treating them. One way to focus more on prevention is to view injury incidents as three distinct phases: pre-event, event, and post-event.

Each injury event phase is affected by human, hazard, and environmental factors that contribute to injury. Each injury event phase and each contributing factor offer opportunities for action that can affect the outcome of the incident. Together, the phases and factors of injury incidents make up a matrix (Haddon 1973; Haddon and Baker 1981) that can be used to systematically identify ways to prevent and reduce the severity of a specific type of injury. The Haddon Phase-Factor Matrix is summarized in table 13.1. The following description of the characteristics of hazard, human, and environmental factors summarizes the parts of the matrix.

Table 13.1 **Haddon Phase/Factor Matrix**

Phases	*Factors*			
	Human Factors	**Hazard Factors**	**Physical Environment Factors**	**Sociocultural Environment Factors**
Pre-Event Factors that determine if an incident will occur (Before the incident)				
Event Factors that determine if an injury will result from incident (During the incident)				
Post-Event Factors that determine if the severity of injury can be lessened (After the injury)				

Hazard Factors

Contrary to what most of us believe, the specific cause of all injuries is the transfer of energy. Energy is either delivered to the body in amounts in excess of the body's injury thresholds (burns, lacerations, falls) or some type of interference with the normal exchange of energy within the body occurs (drowning, suffocation). What most of us usually assume to be the cause of an injury — a knife, a campfire, the lake, a tree root — is actually the transmitter of the energy, and it is referred to as the "hazard" or "vector." Thus, the cause of death in automobile collisions is usually mechanical energy transmitted to the victim by the hazard — the automobile. Burns are the result of thermal energy delivered to the victim by a hazard such as hot liquids, flames, or hot surfaces.

The characteristics of individual hazards may prevent or contribute to injury in various ways. For example, the characteristics of the interior of the camp van usually determine the type and severity of injuries to passengers in a collision. More examples of hazard characteristics that may affect injuries are listed in figure 13.2.

Figure 13.2 **Examples of Hazard Factors an Characteristics that May Contribute to Injuries**

Vehicle	Size Engine horsepower Type of tires, brakes
Ground Trail	Compaction Soil composition Water content Surface material (woodchips, asphalt, etc.)
Lake	Water depth near shoreline Water temperature Water quality Water clarity Condition of bottom surfaces
Ax	Weight/length Condition of handle Sharpness
Stairs	Texture of surface Color of paint, materials Steepness Handrail

Analysis of injury patterns at camp should always include identification of the hazard for a specific type of injury. Often equipment or consumer products have specific characteristics that contribute to injury. For example, wooden paddle handles can crack causing splinters and blisters, or reflective bows on aluminum boats can cause sunburn. Some camps paint these bows brown. Injuries can be prevented and reduced by modifying some injury hazards. For example, the addition of siderails to bunkbeds specified in ACA standards (1993) is one kind of modification made to a hazard. Providing nonslip surfaces on shower floors is another example.

Figure 13.3 **Examples of Human Factors That May Contribute to Injuries**

Physiological Factors	Alcohol use Nutritional status Physical size Physical conditioning Neuromuscular maturity Respiratory maturity Cardiovascular maturity Eye-hand coordination
Social-Emotional Factors	Stress level Fatigue Knowledge of hazard
Developmental Characteristics	**School Age** Imitate heroes' behavior Seek social/ peer acceptance Try to prove their competency Don't fully understand cause/and effect Can't see long-term consequences Immature perception: movement, distance, speed Growth in height exceeds muscle coordination **Adolescence/Young Adult** Need for independence/freedom Seek social/peer acceptance Prove self-worth by risk-taking Challenge rules Feel indestructible Limited view of long term consequences of actions,

Human Factors

Those characteristics of people that help them resist injury or reduce their resistance are considered human factors. Both physiological and emotional characteristics are included in this category. Developmental factors are especially important in school-age and adolescent campers. Camp staff often assume campers in these age groups are more physically and socially developed than they actually are. Young adult staff also have developmental characteristics that can contribute to injury. See figure 13.3 for examples of human factors, including school-age and adolescent developmental characteristics.

The camp community assessment used in designing the health program is an important source of information that indicates camper and staff characteristics that could influence various injuries. For example, the wide range of physical development among the junior high age group is a classic human factor that could contribute to injury. Two twelve-year-old boys may differ in height by as much as six inches and in weight by twenty pounds or more. If these two boys collide in the course of a soccer match, their difference in size greatly increases the risk of injury. A common approach to reducing this risk is grouping sports participants by size and ability rather than by age (American Academy of Pediatrics 1989; Ostrum 1993).

Environmental Factors

The physical and sociocultural environments at a camp contribute significantly to both injury prevention and occurrence. Various aspects of both indoor and outdoor physical environments are factors in injury. Examples of these aspects are:

- Air temperature and humidity, rain, fog, glare, wind
- Level of crowding, noise, activity
- Accessibility of exits/doors
- River current, wave height, clarity of lake water, flooding
- Fences around swimming pools
- Accessibility of emergency services

The sociocultural environment of the camp community is very important to injury prevention. These factors include the influence exerted by the camp traditions, philosophy, organization, and policies. The overall atmosphere in the camp, including stress levels, activity levels, and attitudes about protecting members of the camp community from injury, are other aspects of the social environment that influence injury prevention.

General societal attitudes that perpetuate injury risks can carry over to campers and staff and create major obstacles for all prevention efforts. These counterproductive attitudes may exist among individuals and groups, or even the camp community as a whole:

- Use of alcohol is acceptable
- Risk taking is good
- I am "safer than average"
- Experience is the best teacher
- Some accidents can't be avoided
- Boys will be boys; girls will be girls
- It's a tradition — we've always done it this way

Other sociocultural aspects of the camp environment can positively affect injury prevention and control efforts. Camp policies and procedures convey important messages and provide guidance for individual and group behavior that can reduce the potential for injury. Examples of these types of environmental factors are:

- Enforcement of state and federal laws (seat belts, life jackets)
- Activity policies and procedures in place and practiced (no swimming without a lifeguard)
- Camper-management practices (quality of camper supervision and staff to camper ratios)
- Adherence to ACA standards
- Clear guidelines regarding staff personal behavior as role models for campers
- Use of an injury management plan
- Use of a risk management plan

The Value of Using Injury Phase/Factor Analysis

Systematically looking at all the identifiable factors that might contribute to an injury can serve several important purposes for camp staff and administrators. It can (1) help staff members consider aspects of injury situations they may not have recognized before; (2) refocus attention from placing blame to describing factors that can be changed; and (3) increase injury control options by identifying all contributing factors as potential points for prevention and intervention.

Involving all levels of camp staff in injury factor analysis can be beneficial to the camp. Use of the phase/factor form in table 13.1 to organize this process can be approached in many ways. For example, an activity leader might use the form to examine factors that contribute to a specific common injury in his or her area. Or cabin counselors might use it to identify human and social environmental factors that seem to contribute to falls in their cabins. Even the kitchen staff, working as a group, could use the form to analyze conditions that contribute to cuts or burns in their work areas. Camp administrators and maintenance staff could analyze factors that might lead to potentially fatal injuries from backing vans. Or, a group of counseling and trip staff could brainstorm together to identify factors that contribute to development of camper blisters or sunburn on trips. These are just a few ways to use phase/factor analysis.

Injury factor analysis encourages problem solving and creative thinking among staff. Focusing on multiple contributing factors allows staff members to recognize the concrete ways in which they can be proactive in injury prevention. Factor analysis helps staff see elements of the physical and social environment they can affect and change. It also helps staff see aspects of camper development they might not have been aware of before. Finally, the process helps staff recognize aspects of specific hazards that can be modified or replaced with safer alternatives.

Injury Control Step Three: Developing Strategies and Countermeasures

Staff members should systematically develop specific measures to control injuries at camp, and the measures should be based on a completed analysis of contributing factors. In many camps injury management is limited to first aid and emergency treatment after injury occurs. This may be effective in reducing the severity of injury outcomes, but it does not reduce the frequency of injury. William Haddon (1973) devised a list of ten points for intervention that can be used to develop prevention and control strategies for any type of injury. The majority of Haddon's (1973) "countermeasures" focus on interventions that could be used before injuries actually occur. Using this list helps camp staff and administrators plan ways both to prevent and treat injuries. Although the ten countermeasures include human factors, they emphasize the importance of changing the environment and the hazard. These are the factors most commonly neglected in injury prevention programs. See Appendix G for a list of Haddon's ten counter measures and a list of examples.

Using the List of Countermeasures

One of the main goals in developing an injury prevention program is to gain the active participation and encourage the creativity powers of staff members. As with analysis of contributing factors, developing prevention strategies should be an educational experience for staff. Using the list of Haddon's countermeasures as a guide for brainstorming, groups of staff can devise injury prevention strategies. See Appendix G for a sample factor analysis and application of Haddon's countermeasures. Injury experts (Micik, Yuwiler, and Walker 1987) stress the value of a group approach in working through Haddon's list. A group of staff working together will generate a greater number of and more unique options than those developed by individuals working alone. Staff groups also can effectively evaluate the usefulness of options, creating ideas for their implementation and setting priorities among them (Micik, Yuwiler, and Walker 1987).

Creative thinking about injury prevention can be cultivated among staff by allowing them to brainstorm freely and encouraging them to include all possible options, even those that may seem farfetched. The initial objective should be to generate a very large list of options. For some types of injury, use of authoritative sources (i.e., American Red Cross, National Archery Association, American Academy of Pediatrics, etc.) may help stimulate ideas. Staff and administrators together should go through the list generated and identify those strategies that can be easily implemented right away, those that will take more planning and effort to initiate, and those that might be achievable with more thought and analysis. As with factor analysis, the process of considering potential strategies is an important part of staff development.

Injury Control Step Four: Implement a Plan of Action

It may take more than one summer to put an injury control plan into place for specific injuries. Some camps will need to begin by improving their injury data collection methods. Others will be much further along in the process. Issues that need to be considered when implementing injury management efforts in camp include (1) the importance of "passive" strategies and (2) the teaching of staff, campers, and parents about injury management.

Passive Strategies

Use of passive strategies should be a priority in camp injury control plans. Passive strategies are those that do not rely on individual behavior (Micik, Yuwiler,

and Walker 1987). An example of a passive strategy is the use of mixing valves on hot water heaters that supply showers. Once installed, maximum water temperatures are automatically limited, reducing the risk of scalding, with no action required by the individual taking a shower.

"Active" injury control strategies, by contrast, require direct participation and depend on changing people's behavior. Having campers and staff apply sunblock several times a day on canoe trips is an active strategy. Each individual must make an overt decision and carry out the strategy several times a day. If a camper has not done this before or doesn't think it is worthwhile, he or she may not follow through and risk of sunburn is very great. See figure 13.4 for other examples of active and passive strategies.

Figure 13.4 **Examples of Active and Passive Strategies**

Active	Keeping shoes laces tied
	Wearing lifejackets
	Teaching staff CPR
	Increasing fluid intake in hot weather
Passive	Guards and shields on power tools
	Speed bumps on camp roads
	Side rails on bunk beds
	Smoke detectors

The most successful injury control efforts incorporate as many passive strategies as possible. This is not because the goal is to eliminate personal decision-making or accountability, but because passive approaches are the most efficient and reliable ways to consistently protect large numbers of people. The consistency and reliability of protection provided by passive strategies are especially important in camps that primarily serve children and adults with special health needs.

Teaching, Staff, Campers, and Parents About Injury Control

Nurses should focus on the process of identifying and managing injury risks and not just teach about specific risks when educating staff, campers, and parents about injury control. If staff are actively involved in analyzing injuries and developing countermeasures, they naturally will become well educated about the

process of injury control. Campers and parents, however, need to learn that injury prevention is a high priority at camp. Using injury control to justify camp rules, procedures, and practices for campers and parents is part of the nurse's role in education.

Another way for nurses to teach staff and campers about injury control is to recognize and commend those who identify injury risks or use good injury prevention techniques. Nurses and camp administrators are quick to recognize unsafe behavior or situations and call attention to them. So, too, they should identify safe behavior and well-managed situations or environments as part of effective injury control programs. The nurse and camp administrators should acknowledge and reward staff for good injury prevention efforts. This recognition should not be based on a reduction in the number of injuries because this could discourage staff from reporting incidents. Giving credit for staff efforts also can help overcome the resentment that some returning staff might feel toward changes they perceive as requiring more work or supervision, loss of a privilege or assumed fringe benefit, or change in a longstanding camp tradition.

Injury Control Step Five: Evaluate the Results

Formal Evaluation

The final step in a sound injury control program is to evaluate the outcomes. Formal evaluation might include calculation of injury rates before and after injury prevention strategies are implemented. Measuring time lost from activities by injured campers and staff is another way to assess the effectiveness of injury reduction. This can be tracked in the health center as part of recordkeeping for individual injuries and then totaled for the session or season.

In addition, health care costs in terms of physician and ER visits can be calculated and compared from season to season. However, this approach has some important limitations. Health care expenses increase constantly, making it difficult to determine effectiveness based on expenses alone. In addition, emphasis on reducing costs may make staff hesitant to report less severe injuries to the camp nurse. For this same reason, evaluation should not focus on injury rates, frequency, or severity alone. It is essential that staff and campers report all injuries to the nurse. If staff do not send an injured camper to the nurse or report an injury of their own because they are concerned about negative consequences, serious harm can result.

Informal Evaluation

Informal evaluation methods can be just as effective as formal evaluation methods, especially in smaller camps. Observations of camper and staff behavior,

activities in progress, and the camp program in full operation can be good sources of information about prevention effectiveness. Often, once injury programs are begun, administrators and staff become more sensitive to and observant of human, hazard, and environmental factors that create injury risk. Changes in staff attitudes about injury prevention are an important type of evaluative data that indicate the success of injury control efforts.

Role of the Nurse in Developing an Injury Control Plan

While injury control should involve all camp staff, the professional nurse can provide leadership and expertise that other staff do not have. As a health program manager, the nurse should be responsible for collecting and summarizing information about ongoing injury patterns in camp and organizing plans. As an educator and consultant, the nurse should help staff learn how to apply the techniques of phase/factor analysis and how to review the list of countermeasures. The camp nurse should be a collaborator, consultant, and member of the community helping to implement and evaluate strategies.

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CHAPTER 14

Working With Others in the Camp Community

Kris Miller Lishner and Karen D. Busch

Nursing practice in most camp communities is like working in a very small town. In addition to the informality, spontaneity, and warmth, camps offer members of the community, the challenges associated with close living and working relationships. Resistance to change, conflict, and apathy can be problems in camp, just as in other settings.

Developing trust and good interpersonal relationships with administrators, staff, campers, parents, and other health care providers is essential for the nurse. It is important to work quickly to establish relationships with staff and campers at the very beginning of camp. First time camp nurses often are not prepared for how soon the camp season ends. There is no guarantee that the nurse will have a positive relationship with everyone at camp, but the following suggestions will help foster successful and satisfying relationships with most campers and staff.

- Identify and experience the unique aspects of the culture in the camp
- Try to see camp from the viewpoints of other staff, campers, and parents
- Promote good communication and conflict management skills whenever possible

Experiencing the Camp Culture

Adapting to the culture of the camp community is often a new and unfamiliar experience for the novice camp nurse and for the nurse who changes camps. A camp's

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culture is passed on from session to session and season to season (sometimes from generation to generation) through the staff and campers. Interpreting and respecting the culture of the camp community is necessary for the nurse to be effective as a professional, a camp leader, and a community member. Approaching camp nursing as a cross-cultural experience can be helpful in this process.

Camps vary regarding most of the characteristics that define all specialized cultures: unique traditions and values, distinctive language, dress, and foods. Specialized roles, rituals, and rules of socialization also comprise part of the culture in most camps. Some camps have dozens of unique cultural traits; others have only a few. Some of these characteristics may be quite visible and apparent immediately to the new camp nurse. A few examples are included in figure 14.1.

Figure 14.1 **Visible Characteristics of Camp Culture**

Clothing	Some camps have specific uniforms that are worn by campers and/or staff. Different types of clothing may become an unofficial uniform each summer. One year boxer underwear that extends beyond the bottoms of regular shorts may be in. The next year a headband made in arts and crafts may be considered essential for staff and campers.
Names	Having unique names for everyone is a common part of culture in many camps. Some refer to staff as *Uncle So-and-so* or *Miss So-and-so*. At other camps new names are created for everyone—Squeeky, Skeeter, Logo, Teddy Bear Legs, Moose. Camp names may be associated with personal characteristics or responsibilities.
Language	Unique words for locations and activities in camp are common. Many camps have special terms for certain foods, such as *bug juice*, a standard drink at many camp meals. Camp bathroom names (usually referring to individual buildings) could be the subject of an entire book—UNo, Suzy, HiHo, County Seat, Think Tank. The building the nurse uses as a base is still called the Infirmary in many camps. Fortunately, this terminology is changing, and Health Hut, Health Center, and other wellness-oriented terms are becoming more common.
Customs and Traditions	Each camp has unique traditions or customs that continue from year to year. Sometimes these revolve around competitions between various groups in camp or other all-camp events: "color wars" (Red vs. Blue, etc.); "Wacky Olympics"; counselor hunts; backwards days; all-camp cookouts. Unusual and outlandish camp legends also are part of the culture of many camps.

Less obvious aspects of a camp community's culture include informal power structures, communication networks, and unstated behavioral norms. It is possible to spend a season at a camp (or several seasons) and feel very much like an outsider when camp is over. Nurses especially are likely to remain outsiders if they don't get actively involved in the community culture or are unwilling or unable to leave behind the culture of the traditional health care system.

Unlike many campers and staff, nurses often do not return each summer. As a result, the camp frequently must adapt to a new nurse. Each new nurse must find a way to become an "insider" and full member of the camp community. The nurse is evaluated by others at camp based on his conformity to the criteria for community membership. Criteria vary from camp to camp, but they usually involve investment of time in camp activities, and knowledge and acceptance of the stated and unstated goals, values, and norms of the community.

Direct participation in as many aspects of camp life as possible is the best way to understand and experience camp culture. Figure 14.2 includes some of the ways nurses can become directly involved in camp culture.

Figure 14.2 **Examples of Ways to Participate in Camp Culture**

- Adopt the informal dress code of the camp to the extent possible
- Use the nicknames, special terminology, and camp language (when appropriate!)
- Spend time out of the health center in the living units and activity areas with campers and staff
- When coverage can be arranged, go on a hike or out-of-camp trip with one of the units
- Participate in special events (skits, competitions) or be a song leader
- If you have a special talent, hobby, or skill, lead an activity for campers/staff
- Be a lookout at recreational swims
- Become a bearer of good news!
- Participate in *all* of the precamp staff training

In order to become a camp insider, the nurse must be willing to leave unnecessary elements of the traditional health care system behind. The harried pace, the jargon, and the dress of acute care and most outpatient facilities aren't part of camp. The nurse's dependence on technology, copious sterile and other supplies, sophisticated equipment, and constant vigilance to impending crisis identifies a nurse as an "outsider." Some camp nurses are very assertive about not taking on non-nursing

tasks at camp. This may be appropriate in camps with large health care programs that are miniature models of the larger, outside system. However, when the camp norm is that everyone pitches in and does some tasks not directly related to his or her primary responsibility, the nurse who flatly refuses will remain an outsider.

Well-intentioned staff or administrators sometimes assign the nurse a stereotypical camp nickname — Shots, Pills, Bandages — which can be very annoying. When this practice has been a tradition in a camp, but is not acceptable to the nurse, the best defense is a good offense. One way for nurses to handle this type of situation is to come up with a camp name on their own that they can tolerate, *before* they get saddled with something they cannot live with. They should choose one before the end of staff training.

Some camps have a competitive cabin/tent check or inspection everyday as a way to encourage good housekeeping and personal responsibility for belongings. The nurse may be the traditional inspector. If competition and judging by an expert are norms in the camp, and the nurse is considered an expert judge, cabin inspection may be an appropriate job for the nurse. However, if the nurse is viewed as a colleague and resource person, and health program goals include promoting self-care, healthy lifestyles, and wellness, others besides the nurse should be involved in monitoring unit housekeeping. Approaches to encourage good housekeeping other than inspection also may be preferable.

Each of the unique aspects of camp culture serves a purpose and is very important to staff and campers, especially those who have been associated with the camp for several years. These are the things that make the individual camp near and dear to the hearts of the community members. To respect and accept as much of the culture as possible without compromising one's own values is necessary to experience camp as a transcultural experience. There may be occasional situations in which the nurse feels that certain aspects of the camp culture may threaten the mental or physical health of members of the community. In most cases, nurses should negotiate small changes to avoid harm and maintain as much of the culture as possible. These steps are more effective than attempting major cultural changes.

Relationships at Camp: Viewpoints and Issues

At camp the nurse works with the director, campers, parents, young adult counseling and activity staff, older staff and families, and kitchen staff. Relationships between these individuals and the nurse will differ significantly, based on their responsibilities. Being aware of some of the perspectives of other staff and issues that concern them is important in developing productive interpersonal relationships. A brief summary of some of the common perspectives held by camp members and issues concerning relationships among members of the camp community follows.

Camp Director

Much like a mayor or city manager (and sometimes, a benevolent dictator), camp directors must handle many competing interests and issues. They are ultimately responsible for protecting the health and safety of everyone in camp, as well as seeing that they all have a good time. Trying to fix the broken washing machine in the staff laundry room, hearing complaints about the food in the dining hall, recruiting qualified staff to replace someone who resigned, keeping the camp advisory group happy, investigating potential contamination of the camp water supply, and reassuring the parents of a homesick camper may all demand the director's attention at once. Camp nurses who are able to recognize the many demands on the director's time and energy try to make their relationship and communication with that person as focused and efficient as possible. Examples of how nurses can work effectively with a camp director are listed below.

Keep Demands on the Director's Time and Attention to a Reasonable Minimum

- Work out as many details of the nurse's responsibilities as possible prior to camp and staff training
- Arrive at camp early to get the health center set up and still participate in all aspects of precamp staff training
- Communicate new ideas and suggestions in writing, when possible
- Keep suggestions concrete, concise, and organized; indicate priorities in terms of camper needs
- To keep lines of communication open, suggest a regularly scheduled short (10–15 minutes) meeting with the director on a daily or every other day basis
- Keep director informed about and suggest solutions to developing problems before they become a crisis

Educate About Nursing and Health Care

- Use facts and figures collected in the camp health program to document health needs and issues
- Use authoritative sources of information in program planning and other nursing roles; share those sources with the director (health care literature, including books, journals, and information from the Association of Camp Nurses, American Academy of Pediatrics, Centers for Disease Control, OSHA, etc.)
- Demonstrate willingness to learn about camp operation

Keep Costs to a Minimum

- Be flexible and willing to consider more than one way to accomplish a health goal
- Use prevention and good planning to reduce unnecessary visits to the emergency room or the camp physician
- Get information about the cost of equipment and supplies needed and potential alternatives before requesting them

While some camp directors may have first aid certifications or other emergency medical training themselves, many camp directors have little knowledge of nurses or of the health care system outside of camp. Their knowledge of nursing and what nurses do may be limited to the administering of first aid in crises and the stereotypes of nurses portrayed in the media, which are reinforced by the misinformation most of the public has about professional nursing.

Historically, camp health care has consisted of "the bandage brigade" that stood by to do CPR and crisis intervention if there was a real emergency. This situation is changing, but most camp directors still do not have readily accessible and reliable information about what nurses can and should be doing at camp. In addition, some directors have had unpleasant experiences with unqualified, underqualified, or poorly motivated nurses in the past.

The camp director may not view the individual nurse as a long-term employee. Some staff members return year after year and become a core of knowledgeable, seasoned employees the director trusts and relies on for good advice. The nurse who will be a short-term employee is at a disadvantage in establishing trust and credibility with the camp director. When camp directors do not understand nursing, they cannot fully evaluate and utilize the skills and abilities of highly qualified nurses. The most effective camp nurses find ways to demonstrate their competence, trustworthiness, and commitment to the camp health program on a daily basis.

The nurse's perspective on the cost of health care may be different from that of the director. While costs are a major concern for the camp director, most camp nurses have worked in agencies or institutions with multimillion dollar budgets. Nurses may have experienced supplies being purchased by the gross, bills being paid by third-party payers, and health care being provided to just a few patients that can generate hundreds of thousands of dollars in payments. Only a small portion of camp resources is devoted exclusively to the health program. In most camps, there is no separate billing for health services and no way to recover health care expenses (including the nurse's salary) except through camper fees. The cost of health center supplies and office visits to the camp physician cannot be discounted on the basis of quantity or preferred provider arrangements.

Understanding the camp director's perspective on health care costs is essential. Camp expenses for health care can be a financial strain on the entire budget. Most camp directors are ready to focus on health promotion and primary prevention when they realize these are good ways to keep the camp community healthy and the cost of health care down. Some directors may need help making the connection between prevention and cost. Most directors need help in finding the best ways to make prevention and health promotion effective.

Campers

Each of the many types of campers (children, adults, families, individuals with special needs) has a different perspective on the role of the camp nurse. These perceptions will depend in part on their previous experiences with nurses. Children comprise the largest population group of campers. Many child campers will view the camp nurse much like a *stereotypical* school nurse — someone who puts on bandaids or looks after them when they get sick. These campers also may perceive the nurse as an authority figure to be feared, a parental figure who can protect them from difficult situations, or a potential ally in a conflict with another camper or counselor. International campers may have culturally defined views of nurses quite different from those in the United States. For example, nurses in England, and several other European countries, and the Middle East have much less independence in patient care and decision-making than American nurses have.

Communicating effectively with children requires knowledge and practice. Nurses who have had little experience with children before coming to camp should spend some time reviewing communication techniques to use with children. Information on child development, especially cognitive development and children's ability to understand ideas and concepts, is important. The nurse frequently will use techniques to help a child express feelings, cooperate, and problem solve. Also, other staff may seek the nurse's help in learning and applying these skills. Because of this, nurses should try to have books and other written materials on communication techniques with children available. Several such resources are listed in the resource section (see Appendix T).

Occasionally campers who are homesick or having other problems adjusting to camp may develop physical symptoms or spend a lot of time at the health center as ways of coping. Often, they need someone to listen to them or express interest in them as individuals. Listening empathetically is only the first step in helping these campers. The nurse should then collaborate with their counselors to help these campers identify the real problems bothering them and develop alternative coping mechanisms. Often, helping the camper make one new camper friend will be enough to help her adjust.

Some children may have more serious problems than adjusting to camp. For example, some campers or counselors with a living unit might tease or pick on

another camper. The nurse and the camp director may need to work together with other staff to identify ways changes can be made in the living unit. In other cases, problems at home may make it difficult for the camper to focus on camp. Camp can be a good place to work through feelings about home situations; occasionally, the child may be better off at home.

During the camp season, nurses will develop relationships with many campers through their direct care provider role and as community members. However, most of the health care program will be implemented through cooperation and collaboration with the other camp staff. Nurses need to work with both staff and campers to help them use the nurse as a resource person, collaborator, and teacher, as well as a direct care provider. The attitudes and behavior of counselors toward the camp nurse are especially important in shaping camper beliefs.

Some ways in which nurses can help campers get to know them in other roles are to make themselves visible to campers in areas other than the center, to participate with campers in unit or small group activities, and to make informal daily visits to each unit. Nurses should let campers know they don't have to be sick to see the nurse. Learning names and verbally recognizing as many campers as possible is a good way for the nurse to help campers get to know her, too. Use of direct eye contact with campers helps in all interactions with children and adults. This practice should be modified when working with individuals from cultures where eye contact is not appropriate. In large camps with two or more nurses, each nurse should become nurse for a particular unit and develop closer relationships with campers and staff in that unit.

Young Adult Staff

Camps regularly employ older teenagers and young adults to fill many staff positions. Most of them are college students who are available for short-term summer employment. They assume a lot of responsibility in caring for their campers and leading various camp activities. The way these young adults interact with the nurse and help implement the health care plan will be greatly affected by their impression of and attitude toward the health care provider. As soon as the nurse arrives at camp, he or she should start building good working relationships with young adult staff who are directly responsible for campers on a daily basis. It is important for the nurse to defend him or herself as a colleague, collaborator, and resource person as these relationships develop.

The majority of young adult counselors are committed, caring individuals who approach their responsibilities seriously. They are, however, young adults, going through the developmental transitions characteristic of this age group. Most lack the life experiences older staff have that provide them with the patience and endurance that adult level responsibility and commitment require. Awareness of these developmental characteristics will help the nurse have realistic

expectations of these young adults and better understand their motivation and behavior. Some general developmental characteristics of young adults, along with behaviors nurses may see at camp are included in Appendix K.

Young adults tend to take health for granted and lack knowledge and experience in taking responsibility for the welfare of others. If the nurse misinterprets what looks to her like irresponsibility, it can lead to conflict between the nurse and these staff. It is possible for nurse-counselor interactions to turn into a tug-of-war over responsibility for camper health: the nurse feels counselors aren't supervising camper health closely enough; counselors feel the nurse is overly concerned about campers and does not have a realistic view of staff responsibilities with campers. Camp directors have to resolve these conflicts to maintain effective functioning of the health care program.

Young adult staff respond best to the kind of communication and management techniques that most people appreciate: positive communication; clearly stated expectations; information and education needed to do the job right; some control and autonomy in work; feedback and constructive advice on problem areas; and recognition or appropriate rewards for successes, even the small ones. While usually not responsible for supervising other staff in their daily jobs, the nurse is crucial in providing staff with interpersonal support, information, feedback, and recognition, especially staff in this age group.

Other Staff

Mature Staff. Among those with whom nurses frequently work are older, mature staff and those who have families with them at camp. Staff who have had professional work experience and/or been parents usually have some understanding of the value of having a well qualified camp nurse available to them as a consultant and collaborator. Mature, returning staff can anticipate the stresses of living and working closely together in the camp community. They often have the skills necessary to manage conflict in their camp working relationships. These staff can view the nurse as a colleague and be willing to assist in implementing the health program by being mentors and role models for young adult staff members.

Veteran Staff. Some staff who have worked for a camp for several seasons can become firmly bound to camp traditions and culture to such an extent that it makes them very resistant to change. Lessening this resistance can be one of the most daunting tasks nurses face. The "we've always done it this way" response to more sophisticated and progressive approaches to camp health care has caused many camp nurses to leave their positions after one summer.

The best way to introduce changes to resistant staff is to recognize and respect those aspects of tradition and camp culture that are central to the uniqueness of the camp. Proposing changes that can be incorporated into existing traditions will be more readily accepted than changes that replace them altogether. For

example, incorporating "clean hands" into the morning cabin inspection adds a new part to old traditions.

Encouraging staff to be the creators of new traditions gives veteran staff an incentive to relinquish outdated or unhealthy traditions. All camp traditions were started by someone at some time. Offering staff the opportunity to be the "founders" of a new tradition can be very appealing. For instance, starting a tradition of wearing outrageous, wide brimmed canoeing hats on canoe trips is one way to motivate campers and staff to avoid sunburn. Another example of creating a tradition is to ask a different camper or staff member to make a unique toast at the dining table before each meal. After the toast, everyone drinks one full glass of water before eating. This new tradition increases fluid intake to prevent dehydration. Having the morning toast with juice may help improve nutrition, too.

Families of Staff. Staff with families at camp often seek help from the nurse for health problems that occur with their children, especially young children. These families may not have a family primary care provider accessible from camp. While the nurse should not replace the family doctor, advice about when younger children should be seen by a physician may be sought. Staff members who are parents always retain responsibility for health decision-making about their children. Unless their children are enrolled as campers, staff who are also parents should have responsibility for the direct care of their children when they are ill. The camp nurse's responsibility for staff family members should be clearly defined and discussed among the camp director, the nurse, and staff members before camp begins.

Food Service Staff. Kitchen or food service staff work and often live within the camp, but may be perceived as "outsiders." Their work schedules and responsibilities often do not allow them to participate in camp life to a great extent. They may, however, have regular contact with the nurse. The nurse works with kitchen staff as a consultant and resource in the areas of nutrition, sanitation, and personnel health. The nurse and kitchen manager work together most often to discuss campers on special diets and health problems of individual kitchen staff. Sanitation is supervised not only by the kitchen staff and the camp director, but also local health department officials.

The nurse must be tactful and sensitive in all interactions with kitchen staff. The entire camp depends on the kitchen functioning efficiently. Problems that cause conflict with kitchen staff or limit their ability to function well as a team can cause a major disruption of the entire camp program. This is one aspect of camp working relationships in which lines of communication and responsibility must be completely clear. Ideally, the nurse should work through the camp director as much as possible; however, he or she may work directly with the head of the kitchen to make sure that any camper with special nutritional needs receives an appropriate diet. If the health of an individual on the kitchen staff is in question, the head of the kitchen, the nurse, and the camp director could try

to resolve the problem collectively. Although, in most situations, the nurse should give relevant observations or suggestions about sanitation and nutritional quality of camp meals to the camp director for appropriate action.

Camp Physician. Many camps have difficulty finding physicians available or willing to serve as camp physician. Some physicians may be hesitant or unwilling to take responsibility for providing medical care to so many individuals with whom they have had no previous contact. Physicians in geographically isolated areas may already have too large a workload with their regular patients or feel unprepared to manage the special populations served by some camps. Camps that have arrangements for coverage by a local physician usually are anxious to maintain those ties, even if the relationship is not ideal. It is important to remember that camp health problems are seldom the first priority of the physician, and it may not be reasonable to expect an immediate response to problems that are not emergencies.

Some camp physicians may limit standing orders or try to restrict the nurse's autonomy in making decisions about camper referrals. This lack of confidence in the nurse often is due to the physician's failure to recognize the capabilities of professional nurses, or her lack of information about the specific qualifications of a particular camp nurse. It is difficult to overcome distrust or lack of respect for professional nurses in the course of a single camp season.

Several steps can be taken to establish a good working relationship based on trust between the individual nurse and the camp physician. The first step is to set up a meeting between the two before camp begins. This provides an opportunity to meet face-to-face, discuss attitudes about health care, camper needs, and approaches to office management. The nurse should take a resume to the meeting and leave it with the physician. Emphasizing the nurse's special strengths in nursing education and/or experience also might be helpful.

Second, once camp is under way, the nurse should accompany campers to physician visits on at least a few occasions. Meeting and talking with the nurse individually, in person or by phone, reinforces the physician's view of the nurse as a competent individual. Third, the nurse can send a written note or letter to the physician along with a camper she is unable to accompany. This increases the directness and clarity of communication between nurse and physician. If written communication is not used, the nurse can follow up with a phone call to make sure all relevant information about an ill camper has been received. This is another good way to facilitate good working relationships.

Parents. Parents and families are not members of the camp community in the way that campers and staff are. Parents usually feel they are part of camp but seldom have a great deal of knowledge of or involvement in daily life at camp. Often they know only what they learn from the camp director and camp brochures, or the information they receive from their children, or what they

remember from their own childhood camp experiences. Parents frequently report that new stories about camp trickle out of their children for weeks, months, and sometimes years after the actual camp experience.

Communication with parents or guardians about health care begins when they are asked to provide the camp with information about their child/dependent's health history and existing health problems. Some parents don't perceive minor health problems as noteworthy. Some may not want to mention a health problem because they fear it might cause the camp to exclude the child from participating. Some parents send health forms to camp unsigned or not completely filled out. Regardless of the reasons, accurate health information about campers is sometimes difficult to obtain.

The message to parents should be clear: their child's health care and health issues are taken seriously and the information they provide is absolutely essential to the camp. The directions sent to parents about filling out health forms, sending complete information with medications, and signing the release form should be as clear and concise as possible. Giving parents a phone number to call before camp begins if they have questions about the forms or other health issues is helpful. Families who have not sent health forms or sent incomplete information with a camper should be contacted by phone. ACA standards require a complete health history on all campers and all staff.

The importance of camper health information is also conveyed to parents when they are contacted by the nurse and camp administrators when their child is ill or injured. Parents are entitled to complete and accurate information about their camper's problem as soon as it is available. The camp director normally will make the initial contact with parents of campers with a health problem. Usually, the parents' relationship with the camp is initiated through the camp director and they are most familiar with that individual. In addition, parents may be less alarmed by a phone call or contact from the camp director than the camp nurse. Once the camp director has told the parents there is a problem, the nurse is usually the best one to describe the nature and severity of the illness or injury and to give recommendations for treatment.

Another way to emphasize to parents the need for clear and accurate camper health information is to provide a letter summarizing the nature and management of significant health problems their child had at camp. The camp also can encourage parents to share this information with their primary care provider at home to ensure continuity of care. For example, if a camper has strep throat at camp and is treated by the camp physician, first the illness and treatment should be discussed with the parents on the phone at the time they occur. Then when the camper goes home from camp, a letter stating the dates the child was ill, the diagnosis made by the camp physician, and the name and length of treatment with antibiotics should be sent home with him. The name and phone number of the camp physician also should be included in the letter in case the camper's

regular physician needs more information about the health problem. Finally, a copy of the letter should be kept in the camp files. Some physicians might want a copy of the letter for their files, in case a parent calls.

Managing Conflict

Because almost everyone on the camp staff, including the nurse, has serious responsibilities and often is under stress, there are numerous opportunities for interpersonal conflict to develop. Camp administrators try to encourage good communication among staff and resolve interpersonal tensions using accepted techniques (Koch and Jordan 1993). Some conflict is inevitable, however.

A good measurement of the extent of staff conflict and the ability of staff to manage it is the amount of conflict experienced among the campers. Campers mirror the staff's ability to manage and resolve conflict. Increased camper conflict should be a signal that conflict resolution and prevention may be needed for both campers and staff. Primary prevention strategies for conflict management based on effective communication can be used just as they can for health problems, and professional nurses often have the communication and management skills needed to help resolve conflicts at camp.

Factors That Contribute to Conflict

Filley (1975) identifies several conditions which contribute to conflict. Among these conditions are a few which might exist in some camp situations:

- Ambiguity of roles and responsibilities
- Barriers to communication
- Frequent need for consensus and joint decision making
- Frequent need for dependence on others

Most camp staff are uninformed about health promotion, prevention, health care, and the related roles of the nurse. As a result, staff can be uncertain of their own responsibilities and those of others when meeting camper health needs. Clearly defined job descriptions and written guidelines specifying ways to protect camper health will decrease conflict. American Camping Association (1993) standards include the need for written procedures and provision of training on staff roles and responsibilities in camp health care. In-service training, periodic staff performance reviews by supervisors, and frequent communication (including staff meetings) also can be used to clarify health-related staff responsibilities.

Effective communication is essential in the interdependent working relationships common in camp. Joint decision making and dependence on others is part

of everyday life in camp. Barriers to communication can make it impossible to work together and should be identified and eliminated whenever possible. Frequent face-to-face contact with staff helps the nurse maintain open communication. This is why it is so important for the nurse to be an active and integrated member of the camp community, not a technician isolated within the health center. It's a good idea for camp nurses to have a good reference on interpersonal communication on hand for their own use, and as a resource for other staff.

Whenever people must work both independently and interdependently, some degree of conflict will arise. Conflict makes most of us feel uncomfortable. However, conflict can be healthy and bring about needed change. The issue is not how to avoid conflict but how to manage it constructively to produce a positive outcome.

Responses to Conflict

People approach conflict in several ways (Northouse and Northouse 1992; Kilmann and Thomas 1975). Successful conflict resolution depends on using a conflict style that best meets the demands of the situation (Northouse and Northouse 1992). Common approaches to conflict are summarized in the following box.

Styles of Approaching Interpersonal Conflict (Northouse and Northouse 1992)

Collaboration	Both sides attend to concerns of the other without subordinating their own. The parties work together to find a solution fully satisfactory to all. It can be time consuming, but win-win solutions often achievable.
Compromise	Concerns of both parties are considered. Both sides usually give up something to achieve a solution. They need to resolve conflict is more important than coming up with solutions that satisfy both sides. The parties may settle for quick solution rather than a creative solution.
Accommodation	One side yields to the needs or desires of the other. Some situations can be resolved quickly and effectively, but it requires one side giving up their concerns for the sake of the other side.
Competition	Needs or issues of the other party are not recognized or addressed. Individuals assertively push their own objective without cooperating to help others to achieve theirs. This approach can result in hostile and destructive working relationships.
Avoidance	Conflict is denied or ignored. Individual neither assert their own interests nor cooperate in aiding others to address their issues. Problems are seldom solved, and change seldom results.

Most experts agree that *collaboration* usually is the most effective, though not necessarily the most efficient, conflict management style. Collaboration requires a lot of effort by individuals on both sides of an issue to make it work. According to Northouse and Northouse (1992), both parties share control as they try to find innovative solutions both can accept. Except in a crisis, a collaborative approach that includes negotiation and consensus validation will result in better follow-through by participants than any other type of conflict management technique. Participants make an investment in the outcome of a problem when they are given the opportunity to share in decision making about that problem. Even though reaching a collaborative resolution can be difficult, it often strengthens relationships.

There are times at camp when less desirable solutions to conflict such as *compromise* or *accommodation* are necessary, especially when contact between the parties is limited. For example, conflicts often arise between the nurse and the camp physician's office over scheduling camper office visits at times convenient for the camp. The nurse may have to accommodate the physician's office in the interest of maintaining the long-term relationship between the camp and the physician.

Competition can result from conflict between staff members. For example, the nurse and the counseling staff sometimes compete over camper health supervision. The nurse becomes concerned about the quality of health supervision when campers develop health problems, and he or she may insist that the counselors take more responsibility for observing signs of illness in their campers. Counselors feel, on the other hand, the nurse expects too much of them and respond by insisting they don't have time to constantly check their campers for signs of health problems. Tension and open hostility between counseling staff and health staff have occurred in some camps because the two sides could not collaborate to find a solution to the conflict.

The nurse or other camp staff may sometimes avoid conflict altogether, thinking the problem is not worth the effort required to resolve it. Unfortunately, avoiding conflict can result in weakened staff relationships which are ultimately destructive to the camp community.

Finally, creative problem solving which is based on a systematic approach is recommended (Northouse and Northouse 1992) to improve the conflict resolution process. Steps in problem solving include:

1. Define the problem (together!)
2. Suggest possible solutions (together!)
3. Identify advantages and disadvantages of the solutions (together!)
4. Select the best alternative (together!)
5. Evaluate the fit between the chosen solution and the problem (together!)

By applying these steps to the problem mentioned above concerning the competition between the nurse and the counseling staff over health supervision of campers, more creative solutions can be generated to meet camper health needs. In the process of discussing differences, the nurse may discover that staff really need more information and opportunities to practice making health observations. Counselors, by contrast, may discover the nurse is concerned about them as well as their campers and that she has the expertise and resources to help them learn how to take care of the campers.

Spending time and energy in problem solving to find win-win resolutions to conflict creates a stronger, more supportive camp community. It also fosters creativity and commitment among community members. Regardless of the degree of conflict or the approach taken to resolution, maintaining open and clear communication is the best form of primary and secondary prevention.

Conflict and Crisis. Most camps experience very few crises during a season, but occasionally they do arise. Addressing conflict during a crisis situation demands precise leadership and direction at the time. Collaboration and group decision making is inappropriate during crisis management. Processing, problem solving, and evaluation of the situation should occur once the crisis is resolved.

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CHAPTER 15

Challenging Community and Professional Issues

Kris Miller Lishner

Some situations may arise at camp that deserve special consideration and preparation by the camp nurse. These situations often involve professional issues or problems in the camp community that mirror those in society at large, such as child abuse, drug or alcohol use, sexuality, or ethical dilemmas. Nurses and camp directors should consider these issues well before camp begins in order to gather resources and prepare to manage these situations.

Ethical and Practice Issues

Camp nurses frequently face ethical dilemmas and/or crises regarding issues such as child and elder abuse, adolescent sexual activity, substance abuse, interpersonal violence, homophobia and racism in their camp communities. These communities are made up of people who bring these issues with them to camp, where they may affect other community members.

Abuse and Interpersonal Violence

Abuse and interpersonal violence in the United States is increasing at an alarming rate and these societal problems may surface at camp. Most camp staff and administrators are aware that parental physical and/or emotional abuse of campers sometimes occurs. Camps often include sessions on child abuse in precamp staff training, and the American Camping Association has books and forms (see Appendix) that can help nurses and other staff recognize signs of abuse.

Abuse and interpersonal violence is a much broader and more complex problem than the image most of us have of parents "beating" their children. As camps serve more populations with wider ranging cultural and life situations, the types of abuse recognized among members of the camp community is becoming more diverse. Camp communities need to be prepared to recognize and respond to any of the following potential of violence or abuse:

- Physical, emotional, or sexual abuse of campers by camp staff or visitors
- Spouse or partner physical/sexual abuse or violence among camp staff
- Physical, sexual, or emotional abuse among family members living at camp
- Fighting or assault between campers or between staff members
- Physical, sexual, or emotional abuse of elderly campers by caretakers, adult children, camp staff
- Physical, emotional or sexual abuse of disabled individuals by parents, caretakers, camp staff
- Neglect of campers' physical and mental health by parents or camp staff

The abuse and interpersonal violence that may be recognized among camp community members cover a continuum from mild to extreme. While obvious physical or sexual abuse is not seen frequently at most camps, more subtle situations that suggest neglect or emotional abuse are more common. For example, nurses may see campers in poor health and with inadequate health care, parental neglect in following recommendations of health care providers or administering medications, or evidence of verbal humiliation or degradation by campers' families.

The camp nurse's responsibilities in responding to abuse and interpersonal violence include assessment, reporting and referral, supporting victims and those who identify victims, and promoting primary prevention. Resources for assessment and recognition of signs of physical, sexual, and emotional abuse are readily available in other sources (see Appendix T). This information should be accessible throughout the camp season, because camp directors rely on the nurse to verify evidence of potential abuse before referring the situation to appropriate authorities.

Nurses need to be familiar with the state laws concerning abuse and understand the reporting responsibilities for both health care professionals and lay persons. Some states may have mandatory reporting laws for health professionals but not for the general public. It is essential to be familiar with the appropriate child protective agencies within the camp's state. Camp policies regarding interpersonal violence and abuse should be clearly defined and all staff instructed in how they should be implemented. In all situations, confidentiality is a primary concern for the protection of both the individuals and the camp.

Social and emotional support for victims and others involved in interpersonal violence or abuse situations is of special concern to the nurse. Most camp staff realize victims usually need referral for counseling and follow-up. Often overlooked, however, is the need for support of camp staff who identify abused campers and for siblings or co-workers of campers or staff involved in abuse or interpersonal violence. The effects of these experiences reach far beyond the individuals most directly involved and can be very upsetting and overwhelming for others in the camp community.

Nurses can play a leadership role in helping camps mobilize resources for prevention efforts to reduce abuse and interpersonal violence in the current generation of campers and staff. Clark (1992) identifies numerous goals and nursing interventions for prevention of family violence. These approaches can be adapted to the camp setting to help community members become violence- and abuse-resistant. Several of Clark's suggestions are included below:

- Help individuals develop effective personal coping skills
- Foster development of strong self-esteem and positive self image
- Develop substance abuse prevention programs
- Teach stress management skills
- Help individuals practice decision-making and independence
- Teach violence reduction and interpersonal conflict management skills
- Help individuals establish enduring relationships outside their families
- Work on changing attitudes about glorification of violence
- Model good communication skills and respect for individual differences

Like other groups in society, camps must recognize and respond to abuse and interpersonal violence. Camps can provide a supportive, close knit, small community environment that can help individuals learn the specific social and interpersonal skills needed to avoid becoming a victim or a perpetrator of violence and abuse. The camp nurse, as the expert on health promotion and primary prevention, should advocate camp as a positive force in reducing abuse and interpersonal violence in our society.

Sexuality

Issues involving human sexuality can be some of the most challenging camp nurses face. Americans have great difficulty openly discussing and confronting issues involving sexuality, sexual behavior, and sexual orientation. Potential problems associated with sexual activity among adolescent campers and single young adult staff include sexually transmitted diseases (including HIV), and unwanted pregnancy. Because the consequences of sexual activity can be life threatening and affect many individuals besides those engaging in sexual activity, camp nurses and camp administrators should prepare to face these issues directly.

Promoting abstinence is never an inappropriate strategy for camps with adolescents and single young adult staff. However, many camps have decided this approach alone is not sufficient and offer teaching, counseling, and referral of staff to physicians or family planning services for contraception or treatment of sexually transmitted diseases (STDs). Some camps have chosen to make condoms readily available to staff. Other camps feel that making these services available encourages sexual activity and limit their approaches to advocating abstinence.

The values and attitudes of each camp community and its sponsoring agency will determine the general approach used in efforts to discourage sexual activity among adolescents and single staff. Nurses who seek camp positions should thoroughly discuss with the camp director the camp's written and unwritten policies regarding sexual activity, birth control, and prevention of STDs *before* they accept a camp position. The nurse should be committed to supporting the camp's programs or policies dealing with sexuality and sexual activity.

Regardless of the written or "understood" policies and methods for responding to inappropriate sexual activity, camp nurses in all types of camps may be faced with staff or camper requests for help or information concerning sexual activity. Unintended pregnancies, assistance in getting birth control pills or condoms, referral for treatment of sexually transmitted diseases, and information about every aspect of human sexuality can confront the nurse at *any* camp. Each camp nurse and each camp must find ways to respond to these issues that are consistent with camp community standards, as well as professional nursing codes of conduct (American Nurses Association 1985).

Attitudes and beliefs about sexuality can result in other problems within camp communities. Sexual harassment, sexual discrimination, and homophobia all impact the quality of camp life and the nature of interpersonal relationships among community members. Policies about the inappropriateness of bias, bigotry, devaluation, and intolerance of any group on the basis of gender or sexual orientation should be thoroughly discussed and guidelines for appropriate behavior and management practices explained to all camp staff. The nurse is often in a position to provide factual information useful in setting policies and educating staff and campers about appropriate behavior.

Attitudes concerning sexual orientation have a tendency to be especially divisive in the camp community. Homophobia has devastating effects on youth who are struggling with their sexual orientation. The greatly increased risk of suicide, drug use, and other serious risk-taking behaviors among gay men and lesbian women (Taylor and Remafedi 1993) justifies rational and humane approaches to discussing sexual orientation in the camp community so that these risks are not increased unknowingly by homophobic attitudes.

Substance Abuse

Substance abuse, including illegal drugs and alcohol, is a problem in American society that concerns everyone, including parents, health care providers, and camp administrators. A recent survey of medications and substance abuse in more than 200 ACA accredited private and agency sponsored camps (Lishner and Busch 1993) suggests that abuse of illegal drugs among campers and staff is an uncommon occurrence. However, camp staff's use of alcohol was viewed much differently by health care providers responding to the survey. More than 56 percent of the respondents said some staff misuse alcohol on their time off from camp.

Concern about alcohol use during time off has been discussed among camp directors for a long time. The young adults who comprise much of the camp staff are in the age group most likely to die from automobile and other injuries that are alcohol related. Alcohol use also is a concern because, depending on the amount ingested, it can remain in the blood for many hours. Elevated blood-alcohol levels have a direct impact on the quality of camper supervision and the nature of interaction with campers. Role modeling for campers also is a consideration. Campers always seem to find out when counselors have been drinking on a night off and may see them in an intoxicated state. These incidents can result in campers interpreting the staff's behavior as appropriate and something they should imitate.

All health and camp professionals agree that prevention of abuse of all harmful substances, including alcohol and tobacco (which are drugs), should be discouraged at camp. Just as with adolescent sexual activity, there is no consensus among camping professionals about the best ways to prevent substance abuse at camp. In the survey of camps mentioned earlier (Lishner and Busch 1993), more than 60 percent of the health care providers responding indicated their camps actively promote substance abuse prevention. Unfortunately, when asked to describe what those efforts involved, the majority of respondents described camp policies that mandate firing of staff or expulsion of campers found to be using alcohol or drugs on camp property. While such exclusionary policies may be useful in removing individuals with substance abuse problems from the camp community, they may simply encourage such individuals to use substances elsewhere.

Effective substance abuse prevention at camp should entail more than exclusion policies. Camp is an ideal setting for primary prevention of substance

abuse, and the camp nurse can play a key role in efforts to establish and maintain strong anti-drug (including alcohol and tobacco) programs that build self-esteem and coping skills, as well as providing alternatives to substance abuse. These efforts can include the types of interventions listed below:

- Develop a strong camp community ethic that substance abuse in any form (including alcohol, the substance most commonly abused) is not "OK," macho, or necessary to have a good time
- Work on changing attitudes about glorification of drug/alcohol use
- Ask the local SADD (Students Against Driving Drunk) group to meet with camp staff
- Provide in-camp, recreational and social activities for staff on their time off
- Teach stress management and coping skills to campers and staff as part of program activities
- Help individuals practice decision-making and independence

Eliminating substance use in camp can be accomplished by removing individuals who use harmful or illegal substances. Helping campers and young adult staff avoid substances in any setting is a goal consistent with and supportable through the goals of camping. Camp nurses can lead efforts in substance abuse prevention by introducing primary prevention measures that build on the existing strengths of the camp community and its members.

Professional Issues

Preparing for the Camp Nurse Role

A crucial issue facing both nurses and camps is specific preparation of nurses for their role at camp. Nurses should understand they must be self-directed and proactive in preparing themselves to do their job well. Content on the camp setting is not included in most nursing curricula, and there are few traditional professional development opportunities such as continuing education programs and in-service classes for camp nurses. Camps with only one nurse or no experienced camp nurses on their staff usually have little orientation materials to offer the new nurse. Resources and strategies for the nurse preparing for camp include camp nursing workshops, networking with experienced camp nurses or other health care experts, and professional literature.

Workshops and Continuing Education Programs. Workshops on camp nursing usually are limited to areas of the country with many camps. Sometimes large camps offer one- or two-day workshops on camp nursing as a service to other camps in their area. In some large cities, university schools of nursing may offer a workshop on camp nursing once a year.

Less than two dozen of these workshops are held each year and may be difficult to locate. Sources of camp nursing workshop listings include *Camping Magazine*, which is published by the American Camping Association. The Association of Camp Nurses also publishes information about workshops in their quarterly newsletter. Nurses can inquire about workshops in their area by contacting their state nurses association, the nearest section of the American Camping Association, or college or university schools of nursing. Sometimes, camp directors know about local workshops. Nurses can help make more workshops available by encouraging local university and ACA sections to sponsor these activities.

Networking. When workshops are not available, networking with an experienced camp nurse is the best alternative. The camp director can help contact nurses who have worked at the camp during previous seasons. These nurses can be helpful to the new nurse by identifying the information and experiences that will be most needed in the position. Sometimes camps can work out arrangements for previous nurses to be available by phone as a consultant during the camp season.

The Association of Camp Nurses (ACN) is an excellent resource for networking with other camp nurses. With more than 200 members throughout the United States, this organization is increasing efforts at the regional level to help members get and keep in touch with one another. The ACN newsletter is another way to contact other camp nurses.

When working in an area where there are several camps, nurses can benefit from establishing an informal camp nurses network for the camp season. Contacting each other by phone, or getting together for a few hours to share ideas and problems several times during the camp season can be very informative for inexperienced nurses. This networking also supports nurses working alone or in relative isolation from the traditional health care system. One of the camps in an area may be willing to help establish such a network by sponsoring a half-day, informal sharing session for camp nurses before camp begins.

When other camp nurses are not available, networking with experts in settings with some similar characteristics may be helpful. School nurses are good sources of information about community resources, communicable disease prevention, child health issues, managing medications away from home, and similar problems that often arise at camp. Community or public health nurses can also be excellent contacts for the camp nurse. Nursing faculty in college or university schools of nursing who teach child or community health may also be able to help camp nurses identify resources for self-directed learning.

Professional Literature. Books devoted entirely to camp nursing are very limited and the quarterly newsletter of the Association of Camp Nurses is the only periodical published exclusively for camp nurses. Books and journals for school nurses and community health nurses can be helpful. Occasionally, pediatric and other specialty journals include articles about camp nursing. Many of these represent personal reflections on the camp nursing role or describe unique types of camps. Few journal articles have focused on significant nursing management or practice issues in the camp community.

Most useful for specific aspects of clinical practice with various populations are speciality nursing texts and journals. Pediatric, geriatric, rehabilitation, community health, and similar types of professional materials provide current information on management of common health problems, prevention, and health promotion that can be adapted for camp.

The American Camping Association maintains a publications catalog containing many books and materials about working with children, camp management, first aid and emergency care available through the ACA Bookstore. Information about obtaining a catalog is located in Appendix T.

Resource Lists. Appendix T provides several lists of resources for camp nurses. Textbooks, journal articles, professional organizations, hot lines, and governmental agencies are included among these resources. Also included is the address for obtaining a bibliography of publications on camp nursing (Wood 1993) that have been published over the last decade.

Nursing Students at Camp

Appropriate use of nursing students hired by camps is a common issue. Many camp directors are not aware of state laws regulating how students may function in health care settings. These laws vary from state to state. Unless they are at camp as a student (enrolled in a nursing course and under the supervision of a faculty member), nursing students' ability to provide health care is usually limited to that of any other staff member functioning as a first aider. In some states, in certain types of health care facilities and under appropriate supervision of a registered nurse, students can perform limited additional skills already learned in their nursing program.

Camps sometimes hire nursing students to function as the camp nurse when they are unable or unwilling to hire a registered nurse. Use of students to replace a professional nurse puts campers at risk for receiving inadequate health care and puts camps at legal risk. Referring to such individuals as a "camp nurse" is in violation of most state nursing practice acts. The student who might accept a job as a "camp nurse" potentially could be charged by the board of nursing as practicing without a license.

Nursing students hired by camps to assist professional nurses as aides or assistants can extend the ability to provide more comprehensive health services. Students hired in this capacity need to work under the direct supervision of the registered nurse. Camp nurses working with a nursing student who is providing health care in camp should be thoroughly familiar with the state laws regulating student practice in the state where the camp is located. The nature of the student's role and the registered nurse's responsibilities to the camp and the student should be well defined and discussed with the camp's legal counsel and/or the state board of nursing prior to the beginning of camp.

Participation in Research

Research is not a common activity in camps, especially health-related research. Interest in and funding of research in child health and the needs of special populations is growing rapidly. The amount of research done in camps will increase, and nurses will become more directly involved in the process as our profession and others pay more attention to health care delivery to the millions of children who attend camp each year.

As camp nurses become more involved in research, knowledge of the ethical and human rights issues that must be addressed in all studies is essential. When the camp nurse knows research will be conducted at their camp, he or she should review basic information about protection of human rights and informed consent, before the research gets underway. If they will be involved in obtaining participants' consent or data collection, the nurse's responsibilities in that process should be thoroughly understood and evaluated for compliance with recognized professional nursing standards (American Nurses' Association 1985a, 1985b).

The American Camping Association's (1993) accreditation process includes conformity with existing codes and federal regulations regarding protection of human subjects. These guidelines extend special protection to several groups, including children, individuals who may be vulnerable because of physical or mental limitations, and pregnant women. Human rights protections in research apply to the nurse as well as all staff and campers as potential participants in research on health care, or any aspect of camp. Familiarity with ethical considerations regarding data collection in the course of nursing practice is especially important for nurses involved in any aspect of a research project at camp.

Contributing to Camp Nursing as a Speciality Area of Practice

It's important for nurses who want to help the development of camp nursing to participate in professional organizations that support and improve camp experiences for people of all ages and backgrounds. The Association of Camp

Nurses is an organization composed of and created exclusively for camp nurses. Membership and participation in this organization gives nurses a chance to network with other nurses with similar concerns and interests. Purposes and goals of ACN include support and development of camp nursing practice through clarification of the camp nurse role, facilitating communication among camp nurses, supporting camp nurse research, and disseminating information developed by camp nurses. The *ACN Newsletter* provides information and articles on clinical, management, and professional issues. The ACN also provides a forum for discussion of future directions for camp health care.

Membership in the American Camping Association offers nurses opportunities to learn more about camping professionals, the accreditation process for camps, and the scope and variety of camp experiences available throughout the United States and the world. ACA regional meetings and national conferences offer the opportunity to meet and talk with camp directors and staff from every imaginable kind of camp.

Nurses can contribute to development of the camp nursing role by writing articles on camp nursing. In-depth, scientifically and theoretically based articles are needed on practice issues such as managing common health problems, medications, prevention, and health promotion. Publications are also needed to help camp nurses develop efficient, cost-effective health care management systems. Articles on camp health care management could be especially helpful in explaining professional nursing and the contributions it makes to camp health care.

All nurses who practice in camps have a vested interested in research that describes, predicts, and explains the impact of nurses on health in camp communities and the impact of camp communities on individual health. Research is badly needed on camp nursing practice and roles, management of camp health care, the impact of camp experiences on healthy lifestyles, and the effects of camp on individuals coping with chronic health problems. Very little camp nursing research has been completed and few funding sources are available to support research. Camp nurses can contribute to these efforts by participating in research, as well as making financial contributions and encouraging others to do the same.

Misconceptions about the role of the camp nurse abound among nurses, camping professionals, and the public. Each nurse who has a camp experience can make important contributions to the recognition and advancement of camp nursing within the nursing profession. Sharing with colleagues and the public the complex and sophisticated nature of the responsibilities and challenges of camp nursing will help dispel the image of camp nursing as a paid vacation. All nurses need to speak out in support of the vital role professional nursing plays in making camps healthy, positive experiences for all members of these unique, small communities.

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Areas Covered in American Camping Association *E* Standards

The American Camping Association health care or *E* standards require the existence and periodic review of a written health care plan that provides general guidelines for:

1. Responsibility and authority of a health manager and other health staff
2. Health care routines, sanitation, record keeping, supplies/equipment, and agreements with outside health care facilities and services
3. Qualifications of the on-site camp health manager
4. First aid and CPR certification requirements for staff
5. Annual approval of standing orders or written health care procedures by a physician
6. Activities/locations where first aid and/or CPR certified personnel must be present
7. Requirements for: signed health histories for all campers and staff; signed permission to obtain emergency medication treatment; health screening of all campers and staff; a health examination within twenty-four months prior to camp for campers and staff
8. Availability of emergency transportation for medical emergencies
9. Requirement for camp staff training and written procedures on responsibilities in health care, use of supplies and equipment, managing medication waste and body fluids
10. Management of routine health care and medical emergencies when health manager not available
11. Information and health records on campers and staff that must be maintained
12. Requirements for storage of medications under lock and administration under prescription or signed instructions of parent
13. Availability of health care shelter and continual supervision of campers in the health center

APPENDIX B

Camp Livewell Health Program Precamp Staff Training Outline

Philosophy and Purpose of the Health Program (1–2 hours)

Staff responsibilities
Health program policies and procedures

- Health records
- Health screening
- Daily health care

Handling emergencies

- General procedures
- Communication
- First aid kits and their use
- Injuries

Health Promotion: Keeping the Whole Camp Healthy (1 1/2 hours)

Children's views of health
Building prevention into daily camp life — yours and campers'

- Nutrition
- Rest and activity
- Hygiene
- Weather and environment
- Coping with stress

Preventing Injuries (1 hour)

Identifying risks

- Specialty and program areas
- Living areas

Strategies to avoid injuries

Preventing Communicable Illnesses — General Measures (1 hour)

Dining room
Living units
Bloodborne pathogens and universal precautions

Preventing and Coping with Common Health Problems (1 1/2 hours)

Coughs and colds
Infections
Bites and stings (snake, insect)
Skin problems-poison ivy, sunburn, blisters
Athlete's foot
Infections
Digestive problems

Common Sense Approaches to Adjustment Problems (1/2 hour)

Bed wetting
Homesickness
Hypochondria

Notes:

APPENDIX C

Camp Livewell Health Education Plan for Staff

Content	Timing	Methods
	Primary Prevention and Health Promotion	
Philosophy and purpose of the health program General staff responsibilities	Precamp staff training	Discussion Handout
Health program policies and procedures Health records Health screening Daily health care	Precamp staff training Review at staff meetings as needed	Discussion Case study Handouts
Staying healthy		
Children's views of health	Precamp staff training Review problem areas at staff	Discussion Previous year stories
Building prevention into daily life: yours and your campers' Nutrition Rest and activity Hygiene Hand washing Weather and environment Coping with stress How to be a good role model	Meetings as needed Continuous	Handouts Poster on staff bulletin board Conference with individual Staff as needed Role playing
Avoiding communicable diseases Dining room sanitation Bloodborne pathogens Use of universal precautions Safe sex	Precamp staff training Review problem areas at staff meetings as needed	Discussion Demonstration/return demo Notes/posters on bulletin board Role playing
Preventing injuries Identifying risks Speciality and program areas Living areas Identifying countermeasures		Group activity–safety Inventory in program and living areas Case study Discussion Previous year stories Injury conference — activity area

Content	Timing	Methods
Preventing common health problems: yours and your campers' Coughs and colds Infections Bites and stings Skin problems Athlete's foot Digestive problems Seizures Asthma	Precamp staff training During group screening At time of camper visit to nurse for treatment of problem Review problem areas at staff meetings as needed	Discussion Previous year stories Handouts Individual conference with staff members(s) Posters on staff bulletin bard Case study Each-one-teach-one
Secondary and Tertiary prevention		
Handling emergencies CPR and Heimlich maneuver First aid kits and their use Injuries Special considerations in program areas	Precamp staff training Review first aid and use of kits prior to campouts as needed Review problems at staff meetings as needed	Discussion Handouts Film Demonstration/return demo Each-one-teach-one
Recognizing and handling camper health problems Daily visual screening Early signs of illness Helping with screening on arrival	Precamp staff training Just before group screening Periodically during nurse visits in living units	Handouts Discussion Previous year stories Demonstration/return demo
Common sense approaches to adjustment problems Bedwetting Homesickness Hypochondria	Precamp staff training As individual situations arise	Discussion Previous year stories Individual conference with staff member Role plying Handouts
Managing specific health problems of individual campers	Immediately following group screening Prior to campouts	Individual conference with staff member(s) Handouts

APPENDIX C

Camp Livewell
Health Education Plan for Campers

Content	Timing and *Person(s) Responsible*	Methods
	Primary Prevention and Health Promotion	
Cleaning up Brushing teeth Showers Clothes and beds Hand washing	Continuously and as special problems arise *Cabin counselor* *All staff* *Nurse*	Cabin group discussion Staff role modeling Individual conferences Demonstration/return demo
How to deal with weather What clothes to wear Slowing down — hot days Getting enough to drink	As needed, based on weather *Program director* *Cabin counselor* *Nurse*	Meal time discussion Cabin group discussion Staff role modeling
Food and behavior in the dining hall Hand washing	First meal at camp and review at each meal *Program director* *All staff*	Large group discussion Demonstration Staff role modeling
Keeping cabin and living areas clean and safe	Morning clean up time and all during camp *Cabin counselor*	Cabin group discussion Demonstration Staff role modeling
Preventing injuries when: Swimming Boating Horseback riding Nature Campouts	First activity period in each program area and continuously in all later activities *Program area specialist*	Cabin group discussion Demonstration Staff role modeling

Content	Timing and *Person(s) Responsible*	Methods
Safety at camp Lost camper Fire Weather emergency Serious injuries	First night campfire *Camp director or program director*	Large group discussion Demonstration/return demo Role playing
Avoiding common health problems Poison ivy Bites and stings Athlete's foot Coughs/colds Blisters Sunburn	Continuously as teachable moments arise *Cabin counselor* *Nature counselor* *Nurse*	Cabin group discussion Demonstration/return demo Staff role modeling
Secondary and Tertiary Prevention		
How to take care of existing health problems Medicines at camp	Screening on arrival day and, continuously as new problems arise *Nurse and cabin counselor*	Individual conference
What to do if you are sick or hurt Coming to the health center	Screening on arrival day *Nurse/screening staff*	Cabin group discussion

APPENDIX D

Injury Summary Sheet

Year _____

Session _____ Dates _____

Enrollment _____ Completed by _____

Injury Category	Unit 1	Unit 2	Unit 3	Unit 4	Total
Falls					
Beds					
Stairs/steps					
Trails/walkways					
Overexertion					
Sports-related					
Lifting					
Pushing/pulling					
Cutting/Piercing					
Knife					
Ax					
Fall on objects					
Power tool					
Burns					
Liquids					
Fire/flame					
Smoke inhalation					
Environmental					
Sunburn					
Heat					
Cold/hypothermia					
Plants (PI)					

Injury Category	Unit 1	Unit 2	Unit 3	Unit 4	Total
Struck by Object					
Person					
Object					
MV – Occupant					
MV – Pedestrian					
MV – Nontraffic					
Submersion					
Choking					
Electricity					
Firearms					
Foreign body					
Poisoning					
Adverse effects of drugs/substances					
Other					
Total per units					
Total all units					

APPENDIX E

Accident/Incident Report Form FM 01

Developed by the *American Camping Association*
(Fill out 1 on each incident or person)

Camp Name _____ Date _____

Address _____
Street & Number City State Zip

Name of person involved _____ Age _____ Sex ____ ❑ Camper ❑ Staff ❑ Visitor
Last First Middle

Address _____ Phone _____
Street & Number City State Zip Area Number

Name of Parent/Guardian *(if minor)* _____

Address _____ Phone _____
Street & Number City State Zip Area Number

Name/Addresses of Witnesses *(You may wish to attach signed statements.)*

1. _____
2. _____
3. _____

Type of incident ❑ Behavioral ❑ Accident ❑ Epidemic illness ❑ Other (describe)

Date of Incident/Accident _____ Hour _____ ❑ a.m. ❑ p.m.
Day of Week Month Day Year

Describe the sequence of activity in detail including what the (injured) person was doing at the time _____

Where occurred? *(Specify location, including location of injured and witnesses. Use diagram to locate persons/objects.)*

Was injured participating in an activity at time of injury? ❑ Yes ❑ No If so, what activity? _____

Any equipment involved in accident? ❑ Yes ❑ No If so, what kind? _____

What could the injured have done to prevent injury? _____

Emergency procedures followed at time of incident/accident _____

By whom? _____

Submitted by _____ Position _____ Date _____

SAMPLE

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APPENDIX E

Medical Report of Accident

Were parents notified? ❑ Yes ❑ No By ❑ Writing ❑ Phone ❑ Other _____

By whom? _____ Title _____ When _____ (Time) (Date)

Parent's Response _____

_____

Where was treatment given? ❑ At Accident Site ❑ Camp Health Service ❑ Doctor's Office ❑ Hospital

If treatment was given at camp, where? _____

By whom? _____ Date _____

Treatment given _____

Was injured retained overnight in camp health service? ❑ Yes ❑ No If so, when? _____

Treatment given _____

By Whom? _____ Title _____

Date released from health service _____

Released to ❑ Camp Activities ❑ Home ❑ Other _____

Treatment given elsewhere than camp? ❑ Yes ❑ No Where? _____

By whom? _____ Date _____

Was injured retained overnight in hospital? ❑ Yes ❑ No If so, which? _____

Where? _____ Date _____ ❑ Out-patient ❑ In-patient

Name of physician in attendance _____

Date released from hospital _____

Released to ❑ Camp ❑ Health Service ❑ Home ❑ Other _____

Comments _____

_____

_____

Persons notified such as camp owner/sponsor, board of directors, etc.

Name	Position	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any contact made with/by the media regarding this situation _____

_____

Signed _____ Position _____ Date _____

Insurance Notification

		Date
1. ❑ Parent's Insurance	By ❑ Parent ❑ Camp	_____
2. ❑ Camp Health Insurance		_____
3. ❑ Worker's Compensation		_____
4. ❑ Camp Liability Insurance		_____

SAMPLE

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APPENDIX F

Information Useful in Understanding and Analyzing Injuries*

Date and Time of Event

Location

In camp; on trip out of camp; staff time off
Description (dock, table in dining hall, shower stall in bathroom, back seat of camp van, top bunk in southeast corner of Cabin 10)

Injured Person

Staff/camper/visitor status; age, sex, race

Nature of Injury

Type (burn, laceration, sprain, puncture, contusion)
Location (left knee, right eyelid, left occipital area of head)
Severity

Cause/Agent of Injury

Intentionality (unintentional; assaultive; self-inflicted)
Activity at time of injury (paddling canoe, riding in camp van, walking on trail, chopping wood, using power drill, hiding during counselor hunt)

Other/Contributing Circumstance

Alcohol or drug use (medication; illegal substances)
Product involvement (Swiss army knife, aluminum canoe, bunk bed)
Competitive activity (group or individual dispute)
Physical environmental conditions (emotional environmental conditions)

Health Care Received

Camp health center, EMS, ER, camp physician

Outcome

Treated and released; admitted to camp health center-# of days, hours; went home; admitted to hospital
Time lost from activities (# hours or days activities restricted or stopped)

**Adapted from: National Committee for Injury Prevention and Control. (1989). Injury prevention: Meeting the challenge. New York: Oxford University Press.*

Haddon's Ten Countermeasures

Before Injury (Pre-Event and Event Phases)

1. Prevent creation of the hazard.
2. Reduce the amount of hazard created.
3. Prevent release of the hazard.
4. Modify the rate of release of the hazard from its source.
5. Separate the hazard from that which is to be protected by time and space.
6. Separate the hazard from that which is to be protected by a physical barrier.
7. Modify relevant basic qualities of the hazard.
8. Make what is to be protected resistant.

After Injury (Post Event Phase)

9. Begin to counter damage done by the hazard.
10. Stabilize, repair, and rehabilitate the object of the damage.

Selected Examples of Haddon's Countermeasures

1. Prevent the creation of the hazard.

Eliminate trampolines, human pyramids, or horseback riding from camp program
Exclude wood chopping from campcraft

2. Reduce the amount of hazard created.

Trim dead tree limbs around tents, cabins; spray poison ivy
Reduce numbers of participants in specific activities (swimming, boating)
Clear obstacles from trails
Add water mixing valves

3. Prevent/reduce likelihood of release of the hazard.

Use non-slip surfaces on shower floors
Use safety matches
Use pour spouts on fuel bottles

4. Modify rate or spatial distribution of release of hazard from source.

Use breakaway bases in softball
Use seat belts, child restraints
Group athletes by skill, physical fitness, and physical maturity
Install automatic sprinkler systems in kitchen
Use impact protecting lifejackets in water-skiing

5. Separate people in time or space from hazard.

Keep campers away from cooking fires
Limit camp vehicles to roads away from camper areas
Schedule strenuous activities during cooler parts of the day
Use lifejackets appropriate to the activity

6. Separate people from the hazard by a barrier.

Store hazardous materials/equipment in locked areas
Use safety equipment to protect body from balls, bats, and other players
Place fences around swimming pools
Lock boats at night
Use sunblock to prevent skin damage

7. Modify basic qualities of the hazard.

Use lock blade pocket knives
Use softer balls in sports
Find and fill holes on playing fields

8. Make people more resistant to damage from the hazard.

Conditioning of musculoskeletal system
Force fluids in hot, humid weather
Education strategies—discourage alcohol use; appropriate equipment use
Keep stress levels low

9. Begin to counter the damage already done by hazard.

Make first aid kits available in all activity areas
Make emergency transportation available to local hospital

10. Stabilize, rehabilitate, and repair the damage.

Provide treatment and rehabilitation at acute care facilities

Example of Factor Analysis and Application of Countermeasures for Injury Prevention

Type of Injury: Trauma due to falls on steps to an arts and crafts cabin

Situation: Six campers and two staff members have received minor to severe injuries from falls on the steps leading to an arts and crafts cabin during the past six weeks. The nurse has discussed the injury patterns with the camp director, and they have decided to devote one of the staff meetings to analyzing the pre-event and event factors that contributed to these injuries, and to developing countermeasures for prevention of further injuries. They have decided not to focus on post-event factors and countermeasures because their emergency response plan is well developed and they are more concerned about preventing injuries at this time.

Working in small groups, the staff completed the following analysis of the injuries, using a Phase-factor matrix. (See table 13.1).

Staff then worked in small groups to analyze which types of countermeasures might be possible and came up with the following suggestions:

Countermeasures Recommended by Staff

Prevent creation of the hazard

Move the arts and crafts cabin
Take the steps down, put a new door in the back of the cabin and create a new path around the embankment

Reduce the amount of hazard created

Reduce trips up and down the steps by having arts and crafts sessions less often, keeping supplies in the cabin, having activities at in individual units

Prevent release of the hazard; modify the rate of release of the hazard form its source

Put wood chips or crushed rock on the path leading to the steps so mud doesn't collect on the steps in wet weather
Remove the rocks from the surface of the embankment and plant ground cover over the entire area

APPENDIX G

Separate the hazard from that which is to be protected by time and space

Relocate arts and crafts activities to another building
Reroute the heavily traveled path through camp away from the arts and crafts cabin
Provide benches and chairs for informal socialization in an area near the steps
Provide a different night gathering spot for staff

Separate the hazard from that which is to be protected by a physical barrier

Put a gate at the bottom of the steps to keep campers from socializing and playing on the steps

Modify relevant basic qualities of the hazard

Cover the steps with a nonslip surface material
Build a solid railing on each side of the steps so no one can fall through the railing
Completely rebuild the steps AND railing at a more gradual angle

Make what is to be protected resistant

Provide staff with recreational activities as an alternative to alcohol use
Teach campers rules of behavior for climbing the steps

As a result of the staff's "brainstorming," camp administrators were able to identify several measures they could institute immediately. They also made plans to make major changes in the cabin and path through camp for the next season so the steps could be eliminated.

Table 13.1 **Haddon Phase/Factor Matrix**

Phases	*Factors*			
	Human Factors	**Hazard Factors**	**Physical Environment Factors**	**Sociocultural Environment Factors**
Pre-Event Factors that determine if an incident will occur (Before the incident)	Small campers can't maneuver steps Excitment about activity Fatigue due to camp pace	Steps tilted from settling Wood-worn smooth Slick in wet weather	Steps on steep hillside leading to cabin door steps not lighted at night Get slick from rain on path Located on main camp path	Steps have become gathering place on a major route through camp Campers see staff come down 2 steps at a time Cabin a gathering place for staff at night many staff say campers wouldn't fall if they were more careful
Event Factors that determine if an injury will result from incident (During the incident)	Alcohol use involved in one staff injury Small campers can slip under railing onto hillside	Single, one board railing; 3 feet high Railing flimsy-collapsed under weight of 2 falling campers Wood splinters result from almost any contact	Rocky hillside steepness causes high velocity impact from falls often more than one person on steps when someone falls	Eagerness to get to activity causes pushing and shoving on steps
Post-Event Factors that determine if the severity of injury can be lessened (After the injury)	Not an issue at this time. A comprehensive first aid and emergency response system is in place.			

Table 13.1 **Haddon Phase/Factor Matrix**

APPENDIX H

Health History and Examination Form

Health History and Examination Form for Children, Youth and Adults Attending Camps **Form FM 08**

Developed and Approved by the
American Camping Association
with the American Academy of Pediatrics

Mail to the address below by _____ (Date)

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.
(This side to be filled in by parents/guardian of minors or by adult campers/staff members themselves.)

Name _____ Birthdate _____ Sex _____ Age _____
Last First Initial

Parent or Guardian *(or Spouse)* _____

Home Address _____ Phone _____
Street & Number City State Zip Area/Number

Business _____ Phone _____
Street & Number City State Zip Area/Number

Second Parent or Guardian or Emergency Contact _____

Home Address _____ Phone _____
Street & Number City State Zip Area/Number

Business Address _____ Phone _____
Street & Number City State Zip Area/Number

If not available in an emergency, notify

Name _____

Address _____ Phone _____
Street & Number City State Zip Area/Number

Health History
(Check. Give approximate dates.)

_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes
_____ Bleeding/Clotting Disorders
_____ Hypertension
_____ Mononucleosis

Diseases
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies (Dates not needed)
_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Other *(Specify)*
_____
_____

Operations or serious injuries *(Dates)* _____
_____
Chronic or recurring illness or medical condition _____
_____
Dietary restrictions _____
Current medications *(Hand with instructions)* _____
Other diseases _____
Name of dentist/orthodontist _____ Phone _____
Name of family physician _____ Phone _____
Do you carry family medical/hospital insurance? ☐ Yes ☐ No
If so, indicate: Carrier _____ Policy or Group # _____
Carrier Address _____
Suggestions on health related information for camp personnel _____
_____
_____

For Female
Has this person menstruated? _____ If not, has she been told about it? _____
If so, is her menstrual history normal? _____ Special Consideration _____

Important — This Box Must be Completed for Attendance*

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____
Witness _____ Date _____
I also understand and agree to abide with the restrictions placed on my camp activities.
Signature of minor or adult camper/staffer _____ Date _____

**If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver which must be signed for attendance.*

Name _____ Date Examined _____ Cabin or Tent _____ Year _____

SAMPLE

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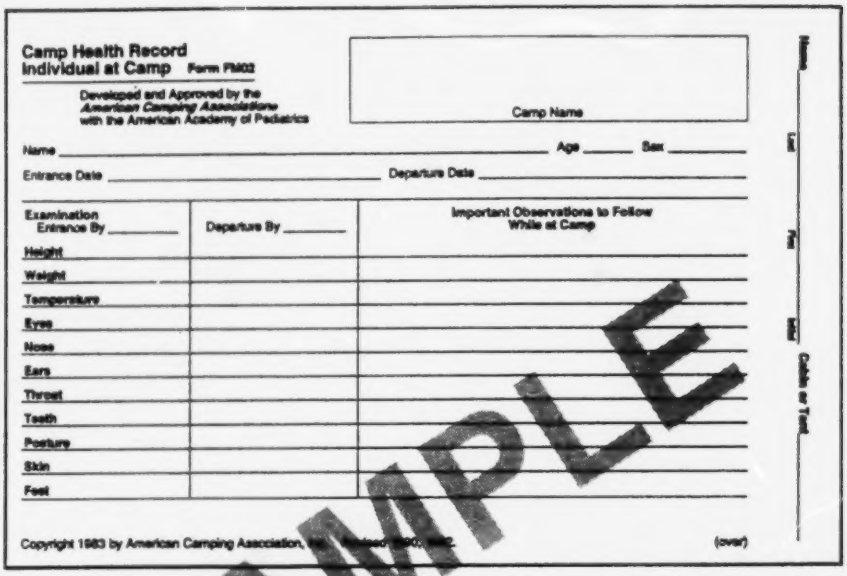
APPENDIX I

Camp Health Record for an Individual at Camp



Camp Health Record
Individual at Camp Form PM02

Developed and Approved by the
American Camping Association
with the American Academy of Pediatrics

Camp Name

Name _____ Age _____ Sex _____

Entrance Date _____ Departure Date _____

Examination Entrance By _____	Departure By _____	Important Observations to Follow While at Camp
Height		
Weight		
Temperature		
Eyes		
Nose		
Ears		
Throat		
Teeth		
Posture		
Skin		
Feet		

Measles _____ Last _____ Polio _____ Last _____ Cuticle or Tuberculin _____

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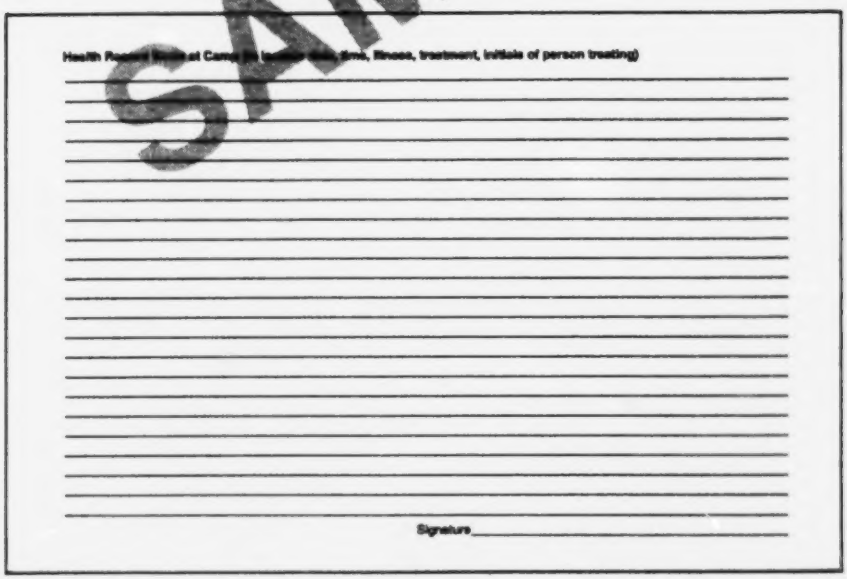
(over)

SAMPLE



Health Record While at Camp (Include date, illness, illnesses, treatment, initials of person treating)

Signature _____

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APPENDIX H

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) Tetanus } DPT* or	1 2 3	1 2
Tetanus Diphtheria } TD* or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past two years. Date Examined _____

In my opinion, the above's condition ❑ does ❑ does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following condition(s)

_____

_____

Current treatment *(include current medications)* _____

_____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

_____

Does applicant have epilepsy? ❑ Yes ❑ No Does applicant have diabetes? ❑ Yes ❑ No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

_____

Any medication to be administered at camp *(specific dosages)* _____

_____

Any medically prescribed meal plan or dietary restrictions _____

_____

Any allergies *(food, drugs, plants, insects, etc.)* _____

_____

Activities to be encouraged or limited _____

_____

Additional Health Information _____

Licensed Physician's Signature _____

Address _____ Phone _____
Street & Number City State Zip Code Area Number

Date of Form Completion _____ *By _____
**Initial if completed by nurse or physician's assistant.*

SAMPLE

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Camp Health, Bloodborne Pathogens, & OSHA*

The Occupational Safety and Health Administration (OSHA) passed new regulations last December concerning occupational exposure to bloodborne pathogens such as Hepatitis B (HBV) and human immunodeficiency virus (HIV). This set of regulations has been established to protect all American workers from the health hazards related to exposure to blood or other potentially infectious materials.

With increased public concern over the spread of AIDS in the general population, and these new OSHA regulations, camps should take a new look at several standards in the Health Care section.

Standards E-1 (Health Care Plan) and E-14 (training for staff) mention specific responsibilities and limits in providing health care, health care routines and sanitary procedures, and use of supplies and equipment. All of those areas address the concerns related to exposure to bloodborne pathogens.

Updating health care plans, procedures, and training in camp will not only address the health concerns of camps but also, for the most part, fulfill OSHA regulation requirements. What follows are highlights of the OSHA regulations and how they may affect camps.

OSHA — Who Is Covered?

OSHA's rule applies to all employees occupationally exposed to blood or other potentially infections materials. "Occupational exposure" means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or body fluids containing blood while performing job duties.

The OSHA regulations do not cover volunteers or state employees or persons acting as "good samaritans" in providing emergency care.

CAMPS — Who Is Covered?

While the federal definition of "occupational exposure" can be interpreted quite broadly, most states contacted indicated they believe it applies to the camp nurse or camp health manager, and any other staff who are expected to routinely perform first aid.

For many camps, that may not include lifeguards or regular counselors. We are seeking a ruling on this from OSHA and will inform you when we hear.

APPENDIX J

OSHA — Key Requirements

1.Exposure Control Plan (effective as of May 5, 1992) OSHA requires that a written exposure control plan be developed that includes, at a minimum: 1) identification of job classes or job tasks with occupational exposure to blood and other potentially infectious materials; 2) procedures for evaluating the circumstances surrounding an exposure incident; and 3) the schedule and method for implementing the various parts of the plan. Training and protection (such as gloves, masks, etc.) must be specified in the plan.

2. Information and Training (effective as of June 4, 1992) All occupationally exposed employees must be given information on bloodborne pathogens and their transmission, and training in prevention measures, work practices, and use of personal protective equipment.

Training records that identify the dates, content, names and qualifications of presenters, and names of attendees shall be kept for at least three years from the date on which the training occurred.

3. Hepatitis B Vaccination (effective as of July 6, 1992) All occupationally exposed employees must be offered the Hepatitis B vaccination series, at the employer's expense. The vaccination is a series of three shots, to be given at 0, 1 and 6 months. Costs in some areas range from $100 to $150 per person for the series.

Individual employees may opt to not be vaccinated, but must sign the following statement:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infection materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Signed _____ Date _____

4. Universal Precautions (effective as of July 6, 1992) Universal precautions for infection control requires employees to assume that all human blood and specified human body fluids are infectious for HIV, HBV, and other bloodborne pathogens. Therefore, the following precautions should be in effect.

a) Work Practices and Personal Protective Equipment Practices designed to reduce the risk of transmission of infectious diseases should be developed and utilized by all employees. Based on current information and recommendations from the American Academy of Pediatrics and the Centers for Disease Control, such policies and practices should be based on the understanding that, even within an area of high prevalence of HIV or HBV infection, the risk of infection resulting from a single cutaneous exposure to blood from a school-aged child or adolescent is minute.

Because of this minimal risk, the only mandatory precautionary action should be washing exposed skin with soap and water. Lacerations and other bleeding lesions should be managed in a manner that minimizes direct contact of the care giver with blood. However, under no circumstances should the urgent care of a bleeding child be delayed because gloves are not immediately available.

CAMPS — Key Requirements

1. Exposure Control Plan (effective as of May 5, 1992) Camps need to review their Health Care Plans and add any necessary elements. A plan should identify the persons assigned health care responsibilities, the training on bloodborne pathogens that will be put in place, the work practices and protective equipment that will be provided, and how incidents will be handled.

If you are ever inspected by OSHA, they will expect to see a stand-alone Exposure Control Plan that is distributed to appropriate staff.

2. Information and Training (effective as of June 4, 1992) All staff need training to carry out their role in the Health Care Plan in general, and in the Exposure Control Plan in particular. Basic information on the transmission of bloodborne pathogens and training in the use of universal precautions is certainly appropriate for all staff in camp, as mentioned in the interpretation to E-14. They should receive specific instruction in the use of gloves, masks, and proper sanitary procedures, along with an understanding of why precautions are important in identified circumstances.

The use of persons with medical licensing and experience to conduct this training will help staff to understand their importance in preventing the transmission of infections.

3. Hepatitis B Vaccination (effective as of July 6, 1992) While the text of the regulation and its explanatory materials clearly focus on health care professionals, it does not automatically rule out others who provide health care. ACA has contacted OSHA for a ruling on who should have the hepatitis B vaccine. Until we have further instructions about seasonal personnel and persons who only provide incidental first aid treatments, we suggest you consider offering the vaccine to your health care manager, and any staff assigned by job description to health care or significant first aid responsibilities.

Professional health care personnel working in other health care settings, such as nurses who also have a job in a hospital, may already have the immunization. However, less than half of hospital employees are currently choosing to be vaccinated.

Obviously, the timing will be a problem for seasonal employees who may choose to be vaccinated. They will need to finish the series at their home or school location. However, even part of the series affords some degree of protection from HBV.

4. Universal Precautions (effective as of July 6, 1992) Universal precautions for infection control requires employees to assume that all human blood and specified human body fluids are infectious for HIV, HBV, and other bloodborne pathogens. Therefore, the following precautions should be in effect.

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Because of this minimal risk, the only mandatory precautionary action should be washing exposed skin with soap and water. Lacerations and other bleeding lesions should be managed in a manner that minimizes direct contact of the care giver with blood. However, under no circumstances should the urgent care of a bleeding child be delayed because gloves are not immediately available.

OSHA — General Guidelines

Handwashing is necessary after any contact with blood or body fluids, and after removing gloves.

Appropriate gloves, gowns, masks, mouthpieces, and resuscitation devices must be provided and utilized for contact with blood or blood-containing fluids and for any procedures that involve exposure to blood.

Instruments that become contaminated with blood or body fluids must be subjected to the generally accepted methods for cleaning and sterilization. Needles (and other "sharps") should be placed uncapped in closed puncture-proof containers, which then should be disposed of as infectious waste.

b) Housekeeping Employees must decontaminate working surfaces and equipment with an appropriate disinfectant after completing procedures involving exposure to blood or other potentially infectious materials.

Persons involved in cleaning contaminated surfaces should avoid exposure of open skin lesions or mucous membranes to blood or bloody fluids. Whenever possible, disposable towels or tissues should be used and properly discarded, and mops should be rinsed in disinfectant.

Regulated waste (e.g. liquid or semi-liquid blood or items dripping with blood) should be placed in closable and labeled or color-coded containers for proper disposal. Contaminated laundry must be bagged and handled appropriately.

5. Post-exposure evaluation and follow-up (effective as of July 6, 1992)
If an employee is exposed to bloodborne pathogens, the employer shall make available to that person a confidential medical evaluation that includes at least a documentation of the exposure, identification of the source individual (unless prohibited by law), collection and testing of blood where permissible by law, counseling, and post-exposure prophylaxis.

Medical records must be kept confidential and maintained for at least the duration of employment plus 30 years.

APPENDIX J

CAMPS — General Guidelines

Camps should consider placing disposable gloves in all first aid kits, with instructions to utilize gloves when providing first aid involving blood. Camps should also provide anti-bacterial soap at handwashing locations and instruct everyone in the importance of proper handwashing.

Unless it is visibly contaminated with blood, contact with urine, stool, vomitus, tears, nasal secretions, and saliva require only handwashing to prevent infection.

CPR masks should be available at aquatic and other designated areas.

b) Housekeeping In general, routine housekeeping procedures for cleaning and laundry, using a commercially available cleaner (detergents, disinfectant-detergents, or chemical germicides) compatible with most surfaces, are satisfactory for cleaning spills (e.g. vomitus, urine, and feces).

For large spills involving blood or other human secretions or excretions, a freshly prepared solution of dilute (1:64) household bleach (1/4 cup diluted in one gallon of water) or other chemical germicide is useful as a disinfectant.

In general, routine sanitary procedures for disposal of waste are sufficient. Disposable towels and tissues or other materials contaminated with blood should be disposed of in a trash container lined with plastic. Tied plastic bags can then be put in regular trash for disposal.

5. Post-exposure evaluation and follow-up (effective as of July 6, 1992) Training for staff should include information on what constitutes an exposure incident (e.g. needlestick, blood splash), and procedures to follow should one occur. Procedures for record keeping and maintaining confidentiality must be developed and followed.

**Campline.* May 1992, 3-6p.

Developmental Characteristics of Young Adults

Approaches to Learning and Job Affected by Developmental Level

According to Murray and Zentner (1993), thinking and learning for young adults are problem centered, not subject centered. They also want to acquire and demonstrate competence and need opportunities for self-expression (Murray and Zentner 1993). Edelman and Mandle (1990) report that health and physical processes are often taken for granted.

Freiberg (1987) explains that young adults use adult mentors and peers as role models and sources of social gratification.

Behaviors Camp Nurses May See

- Not interested in information for information's sake; can accept information/instruction better if they see how to use it daily in camp, or how it can make their work easier
- Want to know how to do their job, but need clearly stated expectations/guidelines, and **frequent** feedback about how well they are doing
- Follow the example of those people in camp they respect and admire
- Respect for and cooperation with the nurse and other camp leaders may not be based on others' skill and background as much as how others treat and interact with them
- Need some opportunities to do things "their way"
- Most welcome opportunities to be creative in their jobs
- May have difficulty understanding the impact of chronic health problems or poor health resources on others
- Usually have had limited experience with potentially serious consequences of minor health problems
- Value highly their free time and recreational benefits of camp

APPENDIX K

Developmental Characteristics that May Affect Relations with Campers

Young adults can be inexperienced at compromising, making sacrifices, or being altruistic (Freiberg 1987). They are capable of problem-solving, reasoning, and analytic approaches, but they frequently take greater risks, using trial and error approaches (Edelman and Mandle 1990).

Behaviors Camp Nurses May See

- May find responsibility for several children or dependent individuals very demanding, exhausting, and confusing because they have had no similar previous experiences (such as being a parent)
- Can become resentful that demands of campers and job seem to be twenty-four hours a day with no relief
- May be restricted in their ability to recognize that thinking and planning ahead can prevent problems and save wear and tear on them as leaders because of limited experience being responsible for others

Basic Information Needed on Individual Health Forms (American Camping Association, 1993)

Health History

(Obtain from all campers and staff in all types of camps)

- A description of health conditions requiring medication, treatment, or special restrictions/considerations while at camp
- A record of past medical treatment (for serious or chronic problems)
- A record of immunizations
- A record of allergies
- Signature of individual, or of parent/guardian of minors

Physical Examination Record

(Obtain from all campers and staff in resident camps in addition to the health history)

- Physical conditions requiring restrictions on participation in the camp program
- Any current or on-going treatment and/or medications
- Date of exam and date form was signed
- Signature of physician, nurse practitioner, or physician's assistant

APPENDIX M

Report of Camper Health Problem

Camp Livewell • 100 Livewell Road • Good Health, USA

Camper Name _____ Date _____

Unit _____

Please share this information with your family physician/health care provider so your family health records can be updated.

Your child/dependent was treated for the following health problem while at camp:

Date of examination/treatment:

Name/diagnosis of problem:

Description of problem:

Name and address of health care provider who examined your child/dependent:

Treatment prescribed (including name, dosage, and schedule of medications):

Instructions for care at home or follow up care needed:

If you have any questions about the information on this form or the health care your child received please call the Camp Livewell Camp director.

Name _____ Signature _____
(Person completing this form)

Title _____ Phone Number ( ) _____

Medication Information Form

Camper Name _____ Date of Birth _____

Parents Address _____ Parent Home Phone _____

Parent Work Phone _____

Physician/Health Care Provider Statement

Name of medication:

Dosage/amount to be given (each dose):

Frequency/specific times to administer:

Duration (days, weeks, or specific date)

Purpose/ anticipated positive effects:

Potential negative side effects that might occur:

Special instructions:

Physician Signature_____ Date _____

Phone_____ Address _____

APPENDIX N

Information to Be Provided by Parent

How long has your child been taking this medication?

What dose/amount and on what schedule (specific times) does your child usually take this medication at home?

Is this a medication your child takes "when needed?" ____ Yes ____ No

If YES, how does your child know when he/she needs to take the medicine?

Special instructions regarding how the medication should be given at camp:

If special supplies or equipment are used to administer this medication (syringe, aerosol machine, etc.) please describe that procedure below:

Other comments or suggestions to help camp staff help your child with this medication at camp:

Signature of Parent or Guardian _____ Date _____

Medication Record

Name	Unit/Cabin	Allergies	Physician Phone #
JOHNSON, DEBBIE	CABIN # 3 BLUEBIRDS	CHOCOLATE	(888) 555-1212 DR. MARTIN JONES
Primary Staff	**Session/Dates**	**Parent(s) Phone #**	
CASSIE MILLER - CABIN # 3	SESSION # 2 7/5 - 7/16	(888) 565-2121 Mr. & Mrs. JOHNSON	

Scheduled Medications

Medication (Name, dose, route, frequency)	Date / Hour	7/5	7/6	7/7	7/8	7/9	7/10	7/11	7/12	7/13	7/14	7/15	7/16
AUGMENTIN 250mg P.O. T.I.D.	0800	KL	KL	KL	AB	KL							
	1300	KL	KL	AB	KL	D/C'd - Rx completed. K. Wishnew R.N.							
	2100	KL	KL	AB	KL								
RITALIN 20mg P.O. BID	0800	KL	KL	KL	AB	KL	KL	KL	KL	KL	KL	KL	KL
	1300	KL	KL	AB	KL	KL	KL	KL	KL	KL	KL	KL	Home KL

Initials	Care Provider Signature and Title	Initials	Care Provider Signature and Title	Initials	Care Provider Signature and Title
1 KL	Kris Wishnew, RN	3		5	
2 AB	Angela Bennett Drip Reader	4		6	

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Medication Record (cont.)

Name	Unit	Allergies	Unit Staff
JOHNSON, DEBBIE	BLUEBIRDS	CHOCOLATE	CABIN #3 CASSIE MILLER

PRN and ONE-TIME MEDICATIONS

MEDICATION (Dose, route, frequency)	Reasons for Med	Date, Time, and Initials				Effects Noted
TYLENOL 325mg P.O.	C/O HEADACHE	7/11 1540 KL				1700 Reports headache gone KL
CALAMINE LOTION	SKIN RASH	7/12 0800 KL 1200 KL 2100 KL	7/13 0800 KL 1000 KL 1600 KL	7/14 0800 KL 1430 KL		7/12 Some improvement reported KL 7/13 Reports "itching" KL 7/14 "Much better" KL

DOCUMENTATION OF OMITTED DOSE OF MEDICATION

MEDICATION (Dose, route, frequency)	Dose Omitted	Reason for Omission	Initials
Augmetin 250mg TID	7/7 2100	Trip leader and camper forgot pill while on campout	HB
Ritalin 20mg BID	7/10 1300	Refused med-says it makes itching worse	KL
Ritalin 20mg BID	7/14 0800	again refused due to ↑ itching	KL

Checklist of Possible Indicators of Abuse

Form FM 15

American Camping Association

Name _____ Nickname _____

Address _____

City _____ State _____ Zip _____ Phone Number _____ Area/Number

Age _____ Birth Date ____/____/____ Sex ☐ Male ☐ Female

Parent/Guardian _____ Relationship _____

Parent/Guardian _____ Relationship _____

Observations

If more than one person utilizes this form, it is beneficial to use different marks. The first person could use check marks (✓), the second pluses (+), etc.

Observer #1 _____ Date ____/____/____

Observer #2 _____ Date ____/____/____

Observer #3 _____ Date ____/____/____

NEGLECT

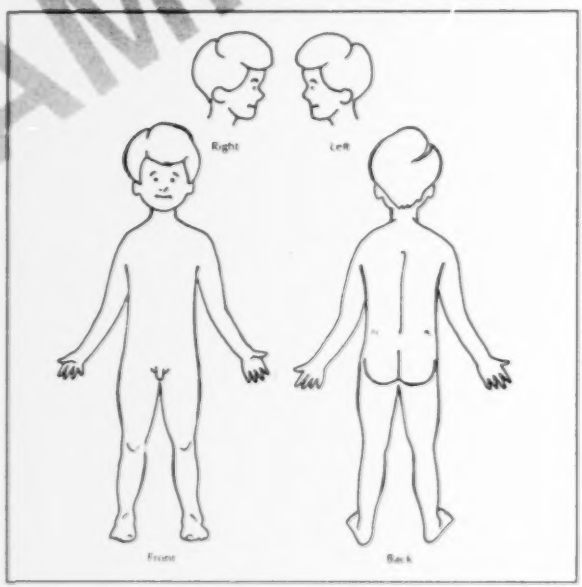
Behavioral Indicators

- ☐ 1. Is truant or tardy often or arrives early and stays late.
- ☐ 2. Begs or steals food.
- ☐ 3. Attempts suicide.
- ☐ 4. Uses or abuses alcohol and/or other drugs.
- ☐ 5. Is extremely dependent or detached.
- ☐ 6. Engages in delinquent behavior, such as prostitution or stealing.
- ☐ 7. Appears to be exhausted.
- ☐ 8. States frequent or continual absence of parent or guardian.

Physical Indicators

- ☐ 1. Frequently is dirty, unwashed, hungry, or inappropriately dressed.
- ☐ 2. Engages in dangerous activities (possibly because he/she generally is unsupervised).
- ☐ 3. Is tired and listless.
- ☐ 4. Has unattended physical problems.
- ☐ 5. May appear to be overworked and/or exploited.

Indicate on the following diagram the areas in which physical injury is evident, using "X" to indicate the location of superficial injuries, "0" to indicate the location of deep injuries and "shaded areas" to indicate areas of apparent burn. Beside each injury or apparent burn, please note the color, size, pattern, texture, and degree of pain.



Name _____ Date Observed _____ Cabin or Tent _____ Year _____

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SAMPLE

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APPENDIX P

SEXUAL ABUSE

Behavioral Indicators

- ☐ 1. Is reluctant to change clothes in front of others.
- ☐ 2. Is withdrawn.
- ☐ 3. Exhibits unusual sexual behavior and/or knowledge beyond that which is common for his/her developmental stage.
- ☐ 4. Has poor peer relationships.
- ☐ 5. Either avoids or seeks out adults.
- ☐ 6. Is pseudo-mature.
- ☐ 7. Is manipulative.
- ☐ 8. Is self-conscious.
- ☐ 9. Has problems with authority and rules.
- ☐ 10. Exhibits eating disorders.
- ☐ 11. Is self-mutilating.
- ☐ 12. Is obsessively clean.
- ☐ 13. Uses or abuses alcohol and/or other drugs.
- ☐ 14. Exhibits delinquent behavior such as running away from home.
- ☐ 15. Exhibits extreme compliance or defiance.
- ☐ 16. Is fearful or anxious.
- ☐ 17. Exhibits suicidal gestures and/or attempts suicide.
- ☐ 18. Is promiscuous.
- ☐ 19. Engages in fantasy or infantile behavior.
- ☐ 20. Is unwilling to participate in sports activities.
- ☐ 21. Has school difficulties.

Physical Indicators

- ☐ 1. Has pain and/or itching in the genital area.
- ☐ 2. Has bruises or bleeding in the genital area.
- ☐ 3. Has venereal disease.
- ☐ 4. Has swollen private parts.
- ☐ 5. Has difficulty walking or sitting.
- ☐ 6. Has torn, bloody, and/or stained underclothing.
- ☐ 7. Experiences pain when urinating.
- ☐ 8. Is pregnant.
- ☐ 9. Has vaginal or penile discharge.
- ☐ 10. Wets the bed.

EMOTIONAL ABUSE

Behavioral Indicators

- ☐ 1. Is overly eager to please.
- ☐ 2. Seeks out adult contact.
- ☐ 3. Views abuse as being warranted.
- ☐ 4. Exhibits changes in behavior.
- ☐ 5. Is excessively anxious.
- ☐ 6. Is depressed.
- ☐ 7. Is unwilling to discuss problems.
- ☐ 8. Exhibits aggressive or bizarre behavior.
- ☐ 9. Is withdrawn.
- ☐ 10. Is apathetic.
- ☐ 11. Is passive.
- ☐ 12. Has unprovoked fits of yelling or screaming.
- ☐ 13. Exhibits inconsistent behaviors.
- ☐ 14. Feels responsible for the abuser.
- ☐ 15. Runs away from home.
- ☐ 16. Attempts suicide.
- ☐ 17. Has low self-esteem.
- ☐ 18. Exhibits a gradual impairment of health and/or personality.
- ☐ 19. Has difficulty sustaining relationships.
- ☐ 20. Has unrealistic goal setting.
- ☐ 21. Is impatient.
- ☐ 22. Is unable to communicate or express his/her feelings, needs, or desires.
- ☐ 23. Sabotages his/her chances of success.
- ☐ 24. Lacks self-confidence.
- ☐ 25. Is self-deprecating and has a negative self-image.

Physical Indicators

- ☐ 1. Has a sleep disorder (nightmares or restlessness).
- ☐ 2. Wets the bed.
- ☐ 3. Exhibits developmental lags (stunting of his/her physical, emotional, and/or mental growth).
- ☐ 4. Is hyperactive.
- ☐ 5. Exhibits eating disorders.

PHYSICAL ABUSE

Behavioral Indicators

- ☐ 1. Is wary of adults.
- ☐ 2. Is either extremely aggressive or withdrawn.
- ☐ 3. Is dependent and indiscriminate in his/her attachments.
- ☐ 4. Is uncomfortable when other children cry.
- ☐ 5. Generally controls his/her own crying.
- ☐ 6. Exhibits a drastic behavior change when not with parents or caregiver.
- ☐ 7. Is manipulative.
- ☐ 8. Has poor self-concept.
- ☐ 9. Exhibits delinquent behavior, such as running away from home.
- ☐ 10. Uses or abuses alcohol and/or other drugs.
- ☐ 11. Is self-mutilating.
- ☐ 12. Is frightened of parents or going home.
- ☐ 13. Is overprotective of or responsible for parents.
- ☐ 14. Exhibits suicidal gestures and/or attempts suicide.
- ☐ 15. Has behavior problems at school.

Physical Indicators

- ☐ 1. Has unexplained* bruises or welts, often clustered or in a pattern.
- ☐ 2. Has unexplained* and/or unusual burns (cigarettes, doughnut-shaped, immersion-lines, object-patterned).
- ☐ 3. Has unexplained* bite marks.
- ☐ 4. Has unexplained* fractures or dislocations.
- ☐ 5. Has unexplained* abrasions or lacerations.
- ☐ 6. Wets the bed.

*(*An explanation is inconsistent or improbable.)*

This form may be used by camp staff to record observations of possible indicators of abuse. Staff should be trained to recognize indicators of abuse, to understand their reporting responsibilities, and to know when to get professionals involved. For more information about child abuse awareness and staff training outlines, order a copy of *For Their Sake: Recognizing, Responding to, and Reporting Child Abuse* by calling the ACA Bookstore at 1-800-428-CAMP.

SAMPLE

BEST COPY AVAILABLE

Camp Livewell
Health Program Annual Evaluation Plan

Annual evaluation of the health program is based on the goals and purposes of the health program. The evaluation involves both formal and informal approaches. The camp director, camp nurse or other health care professional, camp staff, and campers all provide evaluation information about the Health Program. The information is collected and summarized by the camp nurse and the camp director at the end of each camp season. The health program goals upon which the plan is based are to:

1. Promote optimum health of individuals through monitoring of the camp environment and encouragement of appropriate adult role models.
2. Minimize the occurrence of preventable injuries and illnesses through health education and early detection of developing problems.
3. Provide prompt, effective treatment or referral of all injuries and illnesses at camp.
4. Facilitate health-related efforts of everyone at camp through provision of appropriate supplies, resources, and health education.
5. Facilitate provision of all levels of health care through efficient recordkeeping and administration of health program services.

APPENDIX Q

Goals	Type of Evaluation	Information Source	Individuals Involved	Timing
All	Formal	Health care provider evaluation of camp health program questionnaire (a form developed by the camp)	Nurse and/or health care provider	End of camp season or session
All	Formal	Performance appraisal of health care providers based on job description	Camp director/nurse	End of session or camp season
1,2,4,5	Informal	Regular staff meetings	Camp director/nurse	Weekly
1,2,3,5	Formal	Post-camp parent questionnaire (health-related questions developed by camp)	Parents/guardians of campers	End of session
1,2,4	Formal	Staff member evaluation of health program questionnaire (a form developed by the camp)	All administrative, specialist, and counseling staff	End of camp season
2,3,5	Formal	Review of health program log	Nurse and/or camp director	Weekly and end of camp season
2,3,5	Informal	Interview/discussion with camp physician	Camp physician, camp director and/or nurse	End of season
1,3	Informal	Interviews with campers (specific questions developed by the camp)	Cabin groups of campers	End of each session during general evaluation interview with cabin groups
2	Formal	Analysis of injury and illness summary forms	Nurse and/or health care provider and camp director	End of season and end of each session
2	Formal	Analysis of insurance forms and bill for medical services	Nurse and/or camp director	End of season
5	Informal	Meetings Review of health program log	Camp director and nurse	Weekly

APPENDIX R

Standards for Day and Resident Camps — Appendix L
(1993, American Camping Association, Inc.)

Sample Outline of Health Care Plan (E-1)

The purpose of developing a written Health Care Plan is for the administrative and health staff to systematically evaluate the health care needs of their camp. Those needs will vary depending on the age and medical condition of the participants, the type and duration of activities, the proximity of professional medical treatment facilities, and the number and qualifications of the health care staff.

This outline represents a starting point for the development of the camp's plan. Specific standard numbers have been noted in parentheses where applicable. The plan should be developed in consultation with and reviewed by the camp physician.

I. HEALTH CARE NEEDS OF PARTICIPANTS
- A. Typical health care needs of campers
- B. Typical health care needs of staff

II. RESPONSIBILITY AND AUTHORITY OF CAMP STAFF IN HEALTH CARE
- A. Health Care Staff
  1. Number and qualifications of persons (E-4, E-5, E-16)
  2. Job Descriptions (E-4)
  3. Define whether person(s) is (are) on site or on call (E-4)
  4. Housing provided
- B. General camp staff
  1. Responsibility (limits) in providing first aid (E-14)
  2. Locations where first aid-certified persons should be present (E-7)

III. GENERAL ROUTINES FOR CAMP HEALTH CARE AND SANITATION
- A. Policies concerning written health record requirements for campers/staff
  1. Health history — content and frequency (E-8, E-9)
  2. Health examination — content and frequency (E-12)
  3. Parent permission for emergency care (E-10)
  4. Record retention policy (E-18)
  5. Health record log (E-18)
- B. Procedures for health screening(E-6, E-11)
  1. Who administers?
  2. When?
  3. Communication of significant findings to counseling and program staff (C-9)
  4. Pre-/post-trip screening (who? when? what?) (G-7)
- C. First aid (E-5, E-7, E-14, E-15; also F-5, G-4, H-3)
  1. Who administers?
  2. Qualifications of persons administering
  3. Location of first aid supplies (BT-10, E-7)
  4. Record keeping (E-18)
  5. Standing orders/procedures (E-6)
  6. Training of all staff (E-14)
- D. Emergency medical care (E-1)
  1. Who administers?
  2. Qualifications of persons administering
  3. Provision and procurement of emergency transportation (E-13)
  4. Standing orders/procedures (E-6)
  5. Training of all staff (E-14)
  6. Written records to accompany persons off camp grounds (BT-11, D-18, G-8, E-15)
  7. Communication with parents/guardians (B-8)
  8. Procedures for documentation of such care (accident reports, etc.) (E-18)
- E. Daily medical care
  1. Who administers? (E-3)
  2. Hours?
  3. Record keeping (E-18)
  4. Standing orders (E-6)
  5. Medications policies (storage, dispensing, etc.) (E-19)
  6. Communication with parents/guardians (B-8, E-17)
- F. Routine health care
  1. Who is responsible for supervision? (E-3)
  2. Monitoring of personal hygiene
  3. Supervision of orders for daily medications (E-19)
  4. Supervision in infirmary (E-21)

APPENDIX R

G. Supervision of overall camp practices
   1. Sanitation facilities/practices (E-3)
   2. Food service facilities/staff (A-24)
   3. Tripping/travel/out-of-camp programs (D-16 & 17; G-4 & 6)
   4. Grounds
   5. Living accommodations
   6. Program areas

IV. RECORDKEEPING
   A. Health history, and health examination forms (resident camps) (E-18)
   B. Daily medical log (E-18)
   C. Accident reports (E-18)

V. PROVISION OF SUPPLIES AND EQUIPMENT
   A. Health care facility and supplies (E-20)
      1. Location
      2. Equipment/accommodations
      3. Supplies to be available
   B. Supplies to be used by all staff (E-14)

VI. AGREEMENTS WITH MEDICAL PERSONNEL, HOSPITALS, EMERGENCY CARE PROVIDERS
   A. Camp physician
      1. Location — off-site and on call, on-site
      2. Qualifications
      3. Procedures for obtaining and updating standing orders/health care procedures including approval of screening procedures (E-6, E-11)
   B. Hospital/emergency facility (E-1, #5)
      1. Agreement for residential health care
      2. Agreement for emergency health care
   C. Professional therapy (when provided)
      1. Who administers?
      2. Qualifications
      3. Who refers?
      4. Parental permission/report
      5. Confidentiality

APPENDIX S

Date_____

Camp Health Record Log 3

Time	Legal Name	Living Unit	Health Problem or Concern	Health Care Provided	Treated By

APPENDIX T

Resources

This list of organizations and materials is provided by the authors as a tool to be used by professional registered nurses. Many of the publications are written for or designed specifically to be used by nurses and other health professionals with advanced education (including physicians, registered nurses, and nurse practitioners). This material is not intended to be used by less qualified individuals to provide health care for which they are neither legally qualified nor educationally prepared. The authors are not responsible or liable for consequences of the use of the material in the chapter by unqualified staff.

General

Local Institutions and Organizations

Health department
American Camping Association section
Nurses associations
College/university schools of nursing
County medical and dental associations
Cooperative extension services
Planned Parenthood
Child protective services
Poison control center
Area agency on aging

Organizations

American Academy of Pediatrics
141 Northwest Point Boulevard
P.O. Box 927
Elk Grove Village, IL 60009
(Numerous publications and guidelines on child health available)

American Camping Association Bookstore
5000 State Road 67 North
Martinsville, IN 46151-7902
800/428-CAMP
(Publications catalog available)

American Nurses' Association
600 Maryland Avenue SW, Suite 100 West
Washington, DC 20024-2571
202/554-4444
(Also, state nurses' associations in all states)

American Public Health Association
1015 Fifteenth Street NW
Washington, DC 20005
(Publications catalog available)

Association of Camp Nurses
8504 Thorsonveien
Bemidji, MN 56601
218/586-2556
(Publish a quarterly newsletter)

Canadian Camping Association
1806 Avenue Road, Suite 2
Toronto, Ontario, Canada M5M 3Z1
416/781-4717

Christian Camping International
P.O. Box 62189
Colorado Springs, CO 80962-2189
719/260-9400

Books and Journals

Handbook of Community and Home Health Nursing (1992) (Part One: Resource Data) by Marcia Stanhope and Ruth N. Knollmueller. St. Louis, MO: Mosby Year Book.

Help for Children from Infancy to Adulthood, 5th edition (1991) by Miriam J. Williams Wilson. Shepherdstown, WV: Rocky River Publishers. (Available through the American Camping Association)

Professional Nursing at Camp

Organizations

Association of Camp Nurses
8504 Thorsonveien
Bemidji, MN 56601
218/586-2556

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Books and Journals

Resource Guide for Camp Nurses 1993 (A bibliography) by Mary Wood, Librarian, at Betty M. Anderson Library, Intercollegiate Center for Nursing Education, West 2917 Fort Wright Drive, Spokane, WA. 99204-5290.

Camp Health Care (1993) by Mary Casey. Waterloo, Ontario: Conestoga Printing.

Consultation Skills for Health Care Professionals: How to be an Effective Consultant Within Your Organization (1990) by Francis L. Ulschak. San Francisco, CA: Jossey-Bass Publishers.

Nursing: A Social Policy Statement (1980);
Standards of Clinical Nursing Practice (1991);
The Scope of Nursing Practice (1987); and
ANA Code for Nurses with Interpretive Statements (1985). By American Nurses' Association. Washington, DC: American Nurses Association.

Pro-Nurse Handbook, 2nd edition (1993) by Melodie Chenevert. St. Louis, MO: Mosby Year Book.

Role Theory: Perspectives for Health Professionals, 2nd edition (1988) by M. Hardy and M. Conway. Norwalk, CT: Appleton & Lange.

Health Program Development

Books and Journals

Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs (1992) by American Public Health Association and American Academy of Pediatrics. Washington, DC: American Public Health Association.

Community As Client: Application of the Nursing Process (1994) by Elizabeth T. Anderson and Judith M. McFarlane. Philadelphia, PA: J.B. Lippincott.

Community Health Nursing: Promoting the Health of Aggregates (1993) by Janice M. Swanson and Mary Albrecht. Philadelphia, PA: W.B. Saunders Company.

Consent to Treatment: A Practical Guide, 2nd edition (1990) by Ray A. Rozovsky. Boston, MA: Little, Brown.

Cultural Diversity in Health and Illness, 3rd edition (1991) by Rachel Spector. Norwalk, CT: Appleton & Lange.

Documenting Care: Communication, the Nursing Process and Documentation Standards (1991) by F. Fischbach. Philadelphia, PA: F.A. Davis.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives (1990) by the U.S. Department of Health and Human Services, Public Health Service. Washington, DC: Government Printing Office.

Management of Risks and Emergencies (1992) by Connie Coutellier. Kansas City, MO: Camp Fire Boys and Girls. (Available through the American Camping Association)

Nursing Documentation: A Nursing Process Approach (1991) by P. Iyer and N. Camp. St. Louis, MO: Mosby Year Book.

Nursing Process: Application of Conceptual Models, 3rd edition (1990) by Paula J. Christensen and Janet W. Kenney. St. Louis, MO: C.V. Mosby Company.

Pocket Guide to Cultural Assessment (1994) by Elaine M. Geissler. St. Louis, MO: Mosby Year Book.

School Health: Policy and Practice (1993) by the Committee on School Health, American Academy Pediatrics, with Philip R. Nadar as editor. Elk Grove Village, IL: American Academy of Pediatrics.

Standards for Day and Resident Camps (1993) by American Camping Association. Martinsville, IN: American Camping Association.

Communication and Human Development

Books and Journals

"An Analysis of the Concept of Homesickness" by M. Baier and M. Welch. From *Archives of Psychiatric Nursing* February 1992, 6(1): 54–60.

A Child's World: Infancy through Adolescence, 6th edition (1993) by Diane E. Papalia and Sally Wendkos Olds. New York: McGraw-Hill.

Communications in Nursing, 2nd edition (1992) by Susan Smith. St. Louis, MO: Mosby Year Book.

Family-Centered Nursing Care of Children (1989) (Chapter 11: Communicating with Children and Families) by Roxie Foster, Mabel Hunsberger, and Jo Joyce Anderson. Philadelphia, PA: W.B. Saunders Company.

How to Talk So Kids Will Listen and How to Listen So Kids Will Talk (1980) by Adele Faber and Elaine Mazlish. New York: Avon Books.

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Interviewing and Helping Skills for Health Professionals (1984) by L. Sherilyn Cormier, William H. Cormier, and Roland J. Weisser, Jr. Monterey, CA: Wadsworth Health Sciences Division.

Parenting in Contemporary Society, 2nd edition (1990) (Chapter 5: Becoming a More Effective Parent—Contemporary Strategies) by Tommie J. Hamner and Pauline H. Turner. Englewood Cliffs, NJ: Prentice Hall.

The Process of Human Development: A Holistic Life-span Approach, 3rd edition (1992) by Clara Schuster and Shirley Ashburn. Philadelphia, PA: J.B. Lippincott.

Health Promotion and Health Education

Organizations

National Center for Education in Material and Child Health
Georgetown University
2000 15th Street, Suite 701
Arlington, VA 22201-2617
703/524-7802

National Center for Health Education
30 East 29th Street
New York, NY 10016

Books and Journals

The Dynamics of Health and Wellness: A Biopsychosocial Approach (1991) by Judith Green and Robert Shellenberger. Fort Worth, TX: Holt, Rinehart and Winston.

Health Promotion: Concepts and Practice (1993) by Alison Dines and Alan Cribb. London, England: Blackwell Scientific Publications.

Health Promotion in Nursing Practice, 2nd edition (1987) by Nola J. Pender. Norwalk, CT: Appleton & Lange.

Nursing Assessment and Health Promotion: Strategies through the Life Span, 5th edition (1993) by Ruth B. Murray and Judy P. Zentner. Norwalk, CT: Appleton & Lange.

The Process of Patient Education, 7th edition (1993) by Barbara Klug Redman. St. Louis, MO: Mosby Year Book.

Teaching in Nursing Practice: A Professional Model, 2nd edition (1992) by Nancy I. Whitman, Barbara A. Graham, Carol J. Gleit, and Marlyn Duncan Boyd. Norwalk, CT: Appleton & Lange.

Wellness Activities for Youth (1993) by Sandy Queen. Duluth, MN: Whole Person Associates. (Available through the American Camping Association)

Health Care for Individuals

Children

Organizations

Association for the Care of Children's Health
7910 Woodmont Avenue, Suite 300
Bethesda, MD 20814
301/654-6549

Society of Pediatric Nurses
7250 Parkway Drive, Suite 510
Hanover, MD 21076
800/723-2902

Books and Journals

Child Health Nursing (1993) by Debra Broadwell Jackson and Rebecca Saunders. Philadelphia, PA: J.B. Lippincott.

Current Pediatric Diagnosis and Treatment, 11th edition (1993) edited by William E. Hathaway. Norwalk, CT: Appleton & Lange.

Ear Disease: A School Nurse Manual (1992) by Terry Owens, M.D. Houston, TX: The Peanut Publishing Company.

Mosby's Pediatric Nursing Reference, 2nd edition (1992) by Cecily Lynn Betz. St. Louis, MO: Mosby Year Book.

Nelson Textbook of Pediatrics, 14th edition (1992) edited by Richard E. Behrman. Philadelphia, PA: W.B. Saunders.

Nursing Care of Infants and Children, 4th edition (1991) by Lucille Whaley and Donna Wong. St. Louis, MO: Mosby Year Book.

Orthopaedics and Sports Medicine for Nurses (1989) by Sharon J. Gates and Pekka A. Mooar. Baltimore, MD: Williams & Wilkins.

Pediatric Diagnosis: Interpretation of Symptoms and Signs in Infants, Children, and Adolescents, 5th edition (1992) by Morris Green. Philadelphia, PA: W.B. Saunders.

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Pocket Guide to Pediatric Assessment, 2nd edition (1993) by Joyce Engel. St. Louis, MO: Mosby Year Book.

Older Adults

Organizations

National Gerontological Nursing Association
1818 Newton Street NW
Washington, DC 20010

Books and Journals

Gerontological Nursing, 3rd edition (1993) and *Caring for the Elderly in Diverse Care Settings* (1990) by Charlotte Eliopoulos. Philadelphia, PA: J.B. Lippincott.

Nursing Care of the Older Adult, 3rd edition (1993) by Mildred Hogstel. Albany, NY: Delmar Publishers.

Pocket Guide to Gerontologic Assessment, 2nd edition (1994) by Annette Lueckenotte. St. Louis, MO: Mosby Year Book.

Individuals with Special Health Needs

Organizations

American Association of Diabetes Educators
500 North Michigan Avenue, Suite 1400
Chicago, IL 60611
800/338-3633 (outside 312 area code)
312/644-2233 (within 312 area code)

American Cancer Society
1599 Clifton Road NE
Atlanta, GA 30329
404/320-3333
(Local offices available in most areas)

American Diabetes Association, Inc.
1660 Duke Street
Alexandria, VA 22314
800/232-3472
(Local offices available in some areas)

American Lung Association
1740 Broadway
New York, NY 10019
212/315-8700
(Local offices available in some areas)

Association of Pediatric Oncology Nurses
11512 Allecingie Parkway
Richmond, VA 23235

Association of Rehabilitation Nurses
5700 Old Orchard Road, 1st Floor
Skokie, IL 60077

Disability Rights Center
1616 P Street NW, Suite 610
Washington, DC 20036

Directory of Organizations Interested in the Handicapped
c/o People-to-People Programs
LaSalle Building, Suite 610
Connecticut and L Street
Washington, DC 20036

Directory of National Information Sources on Handicapping Conditions
Office of Handicapped Individuals
Hubert H. Humphrey Building
Washington, DC 20201

Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785
(Local offices available in some areas)

Medic Alert Foundation International
2323 Colorado
Turlock, CA 95381
209/668-3333

National Asthma Center
875 Avenue of the Americas
New York, NY 10001
800/222-5864

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National Diabetes Information Center
Box NDIC
Bethesda, MD 20892

National Easter Seal Society
230 West Monroe
Chicago, IL 60606
312/726-6200

National Information Center for Children and Youth with Disabilities
P.O. Box 1492
Washington, DC 20013-1492
800/695-0285

Books and Journals

Students with Seizures: A Manual for School Nurses (1991) by Nancy Santilli, W. Edwin Dodson, and Ann V. Walton. Landover, MD: Epilepsy Foundation of America in collaboration with the National Association of School Nurses.

Primary Care of the Child with a Chronic Condition (1992) by Patricia Ludder Jackson and Judith A. Vessey. St. Louis, MO: Mosby Year Book.

See also section on Health Care for Individuals

Communicable Disease

Organizations

U.S. Public Health Service
National AIDS Hotline
800/342-AIDS (English)
800/344-SIDA (Spanish)
800/AIDS-TTY (Hearing impaired)

Books and Journals

AIDS/HIV and Confidentiality: Model Policy and Procedures (1991) by Sharon Rennert. Washington, DC: American Bar Association.

"APIC Guidelines for Selection and Use of Disinfectants" (1990) by Association for Practitioners in Infection Control. *American Journal of Infection Control* April 1990, 18(2): 99-117.

Control of Communicable Diseases in Man (Latest edition), edited by Abram S. Benenson. Washington, DC: American Public Health Association.

Fear and AIDS/HIV: Empathy and Communication (1993) by Suzanne Lego. Albany, NY: Delmar Publishers.

"Guidelines for HIV and AIDS Student Support Services" (1990) by American Association for Counseling and Development, American School Health Association, National Association of School Nurses, National Association of School Psychologists, National Association of School Works—Education Commission, National Association of State School Nurse Consultants, National Coalition of Advocates for Students. In *Journal of School Health* 60: 249–255.

HIV/AIDS: A Guide to Nursing Care, 2nd edition (1992) by Jacquelyn Flaskerud. Philadelphia, PA: W.B. Saunders.

Infection Control in the Child Care Center and Preschool (1991) by Leigh G. Donowitz. Baltimore, MD: Williams & Wilkins.

Pediatric Infectious Diseases: A Problem-Oriented Approach, 3rd edition (1989) by Hugh Moffet. Philadelphia, PA: J.B. Lippincott.

Report of the Committee on Infectious Diseases, 23rd edition (1994) by Committee on Infectious Diseases, American Academy of Pediatrics. Elk Grove Village, IL: American Academy of Pediatrics.

Injury Prevention and Control

Organizations

Consumer Product Safety Commission Hot line
800/638-2772

Books and Journals

"Childhood Injuries: An Epidemiologic Approach" by Nancy Jones. In *Pediatric Nursing* 1992, 18: 235–239.

"Developing a Comprehensive Approach to Injury Prevention" by Kris Lishner. In *Association of Camp Nurses Newsletter* 1991, Spring, pages 5–8.

Injury Epidemiology (1992) by Leon Robertson. New York: Oxford UP.

Injury Prevention: Meeting the Challenge (1989) by National Committee for Injury Prevention and Control. New York: Oxford UP.

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Preventing Childhood Injuries: A Guide for Public Health Agencies (1987) by S. Micik, J. Yuwiler, and C. Walker. San Marcos, CA: North County Health Services.

Managing Health Emergencies

Organizations — State or regional poison control centers

American National Red Cross
Health and Safety
18th and F Streets NW
Washington, DC 20006
(Local offices available in most areas)

American Heart Association
7272 Greenville Avenue
Dallas, TX 75231
214/373-6300
(Local offices available in most areas)

Books and Journals

Management of Wilderness and Environmental Emergencies, 2nd edition (1989) edited by Paul Auerbach and Ed Geehr. St. Louis, MO: C.V. Mosby.

"Pediatric Dental Emergencies" by R.J. Henry. In *Pediatric Nursing* March-April 1991, 17(2):162–167.

Quick Reference to Pediatric Emergency Nursing (1991) by Donna Thomas. Gaithersburg, MD: Aspen Publications.

Managing Medications

Books and Journals

Davis's Drug Guide for Nurses, 3rd edition (1993) by Judith Deglin and April Vallerand. Philadelphia, PA: J.B. Lippincott.

Drug Facts and Comparisons by Facts and Comparisons, St. Louis, MO: Facts and Comparisons. (Updated continuously by subscription or annual hardbound edition)

Handbook of Nonprescription Drugs, 10th edition (1993) by American Pharmaceutical Association. Washington, DC: American Pharmaceutical Association.

Pediatric Drugs and Nursing Implications (1991) by Ruth Bindler and Linda Hawry. Norwalk, CT: Appleton & Lange.

Physician's Desk Reference (Current edition) by Medical Economics Data Production Company, Montvale, NJ: Medical Economics Data Production Company.

Special Issues

Organizations

Children's Defense Fund
25 E Street NW
Washington, DC 20001
202/662-3652 (Publications Department)
(Publications catalog available)

National Adolescent Hotline
800/621-4000

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
301/468-2600

National Clearinghouse for Drug Abuse Information
P.O. Box 416
Kensington, MD 20795
301/443-6500

National Cocaine Hotline
800/COCAINE

Planned Parenthood Federation of America, Inc.
810 Seventh Avenue
New York, NY 10019
(Local office available in many areas)

Sex Information and Education Council of the United States
80 Fifth Avenue, Suite 801
New York, NY 10011

Students Against Driving Drunk (SADD)
P.O. Box 800
Marlboro, MA 01752
(508) 481-3568

APPENDIX T

Books and Journals

Adolescent Health Care: A Practical Guide, 2nd edition (1991) by Lawrence S. Neinstein. Baltimore, MD: Urban and Schwarzenberg, and Williams & Wilkins. (Especially useful: Part XI, Sexuality and Family Planning; Part XIV, Drug Use and Abuse; and Part XV, Psychosocial Problems and Concerns)

"AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect" (1985) by Council on Scientific Affairs. In *Journal of the American Medical Association* 254:796–800.

Child Advocacy for the Clinician: An Approach to Child Abuse and Neglect (1990) by Lawrence Wissow. Baltimore, MD: Williams & Wilkins.

For Their Sake: Recognizing, Responding to, and Reporting Child Abuse (1992) by Becca Cowan Johnson. Martinsville, IN: American Camping Association.

Nursing Care of Survivors of Family Violence, 2nd edition (1993) by Jacquelyn Campbell and Janice Humphreys. St. Louis, MO: C.V. Mosby.

Substance Abuse in Children and Adolescents, (1991) by Paul Schinke. Newbury Park, CA: Sage Publications.

When Sex Is the Subject (1991) by Pamela M. Wilson. Santa Cruz, CA: ETR Associates. (Available from the American Camping Association)

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Tell Us What You Think

As we revise and update this book, it is important that we know how you, the reader, feel about it. Knowing what you find useful and not so useful will help us make a better book. Please answer the following questions.

What is your health care background?

Physician
Registered Nurse
Licensed Practical Nurse
Nurse Practitioner
First Aider
EMT or Paramedic
Student
(describe) _____

What is your relationship to camp?

Health Care Manager
Health Care Staff Member
Camp Director
Educator
Owner
Administrative Staff
Volunteer
Other (describe) _____

If you are working with a camp, what type?

Cay camp
Resident camp
Trip/travel camp
Seasonal
Year-round

Was this book useful to you? ❑ Yes ❑ No

Why or How?_____

_____

What parts are the most helpful? Why? _____

_____

What parts are the least helpful? Why? _____

_____

What did you like or dislike about the format? _____

_____

What information would you like to see added? _____

What information could be eliminated? _____

_____

Other comments_____

_____

Name and address (optional) _____

_____

Please mail this form to
American Camping Association, Creating a Healthy Camp Community
5000 State Road 67 North, Martinsville, IN 46151-7902.

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Creating A Healthy Camp Community

a nurse's role

"When the only tool you have is a hammer, every situation that comes along begins to look like a nail" (Garbarino 1980).

Nurses and camp directors have been hammering away at illness and injury in camps using a hammer solely comprised of first aid and emergency management skills. This book is designed to be an important addition to the tools nurses can use to provide the best possible nursing and health care in their camps. It also can be a tool for camp directors who want to collaborate with professional nurses to make their camps safer and healthier places for their campers.

American Camping Association

Includes:

- Community assessment and program evaluation
- Staff training outline and camper health education plan
- Developing a health program and a written health plan
- Systematic injury prevention and control
- Managing medications
- Documentation and recordkeeping
- Suggested arrival screening procedure
- Discussion of standing orders
- Minimum equipment and supplies for the health center
- Legal/accountability issues in camp health care
- Emergency communication systems
- Prevention of communicable diseases
- Relationships with other staff

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